VETERANS' PERCEPTIONS OF VA HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

APRIL 20, 1994

Printed for the use of the Committee on Veterans' Affairs

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VETERANS' PERCEPTIONS OF VA HEALTH CARE

WEDNESDAY, APRIL 20, 1994

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 8:30 a.m., in room 334, Cannon House Office Building, Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans, Filner, Gutierrez, and Kreidler.

Also Present: Representatives Montgomery and Kennedy.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. This meeting will come to order.

Today's hearing is on veterans' perceptions of VA health care. In the past, this subcommittee has examined a wide range of veterans' health care issues. These have included the long waiting times that many veterans face for outpatient care, the health problems of Persian Gulf veterans and their dependents, the concerns of African-American veterans, VA care for older veterans, VA's ability to meet its mission in time of war, inequities in access to VA health care, VA health care for women veterans, and long waits for specialty care clinics. These hearings have shared a common element: How well is the VA providing services to veterans?

In large part, that is also the subject of today's hearing. I don't believe any veteran should be forced to wait months for a VA specialty care appointment. I don't believe any veteran should be expected to wait all day for routine VA outpatient care. And I don't believe any veteran who has driven hundreds of miles to the VA for a scheduled appointment should be told "Sorry, you'll have to come back tomorrow."

What I do believe is that veterans have earned, should expect and then receive first class quality and first class service from the VA, service that is second to none, service that sets the standard. But today, VA service is less than first-rate too often. In recent testimony, Dr. Headley told this committee that the VA must change and consistently provide veterans and their dependents with first class service. I can not more strongly agree.

With or without health care reform, VA's service to veterans must be improved, but the advent of reform places even more importance on the VA providing better service to veterans and doing that now. Today, the VA and health care providers are poised at the beginning of a new era in health care. Under the President's

health care reform plan, VA will vie more directly with others to serve our veterans. And the VA is expected to expand the range of care it offers to meet the needs of veterans' dependents.

Health care reform clearly presents significant challenges to the Department of Veterans Affairs. Studies have reported that from one-fourth up to nearly one-half of veterans may select a non-VA health care provider if given the option. VA will be challenged to both retain current patients and to attract new veterans to the VA system.

Several years ago, former President Reagan talked about people voting with their feet. In a competitive health care environment, veterans will vote with their feet for health care. To his credit, VA Secretary Brown has recognized that health care reform is an important opportunity for the VA to serve even more veterans, and he has directed the VA to get ready to meet this challenge.

Today, some veterans who want to receive VA health care can't. Other veterans who can use VA don't. While many veterans are very satisfied with the quality of care they receive from the VA, others are frustrated and turned off by their experiences.

VA is an important national resource and asset. Not every health care provider can serve the needs of our veterans. I want the VA to succeed. I want VA not only to survive, but to thrive. I believe it can. But VA must change to meet the very real challenges of a competitive environment. It can meet these challenges and continue its historic mission of providing health care to veterans by providing better services.

To succeed, the VA must change and change today. More than in the past, the VA must better serve veterans, understand what veterans want and respond quickly. This hearing will help identify the changes veterans want in VA health care. It will better prepare the VA to meet the challenges of health care reform in a more widely opened competitive environment. This hearing will provide a real-world look at the changes the VA needs to make.

On many other occasions, this subcommittee has directed VA's attention to opportunities for improving services to the veterans of our country. In some cases, the VA has made the needed improvements, but in others, little change has been realized.

This subcommittee has also shown that there are many highly talented and dedicated people in the VA. At some facilities, these individuals have succeeded in providing better services to veterans. But these improvements are largely the result of individual personal initiatives by one or a few employees at a single facility. These improvements and successes are not widely known. More rarely are they duplicated or repeated. This must change.

While VA may be the biggest health care system in the world, it becomes very small when it comes to sharing information and communicating good ideas among its medical centers and clinics.

There are literally hundreds of ways to better serve our veterans today. Perhaps this subcommittee should conduct a hearing to focus attention on innovative local programs providing better services to our veterans. Maybe then VA would systematically and routinely identify and publicize these service-improving opportunities.

Several veteran service organizations survey and regularly report to local VA management on needed improvements to serve our vet-

erans. In many cases, these recommended improvements aren't costly, but they do require a change in attitude or procedures. Too often, it seems these suggestions for better service take years to be enacted.

The Blue Ribbon Panel on Claims Processing produced useful recommendations. But the challenge of better claims adjudications has not ended. This effort too should be regular and ongoing. Efforts to improve services to veterans shouldn't be given real attention only once in a blue moon.

Our veterans' organizations should be regularly and formally recommending health care service improvements to the VA. And the VA's responses to these recommendations should be regularly monitored by this committee and the service organizations.

There have been enough 5 year plans, task force reports, TQM seminars and working groups. We just don't want plans. We want results and better service for veterans. Change is not always easy, even when it's necessary. The VA is a large ship and large ships can be hard and slow to turn. But when they do not turn quickly enough, they can run aground.

Decisions made by Congress and the Executive Branch will certainly have considerable influence, but ultimately, veterans' decisions will determine the future course of VA health care.

We look forward to hearing from today's witnesses. We want to know what veterans think of the VA health care system and receive testimony on the related issues previously identified by this subcommittee as part of today's hearing.

We are very pleased that the chairman of the full committee has joined us and we'll now yield to him for any statements he might make.

Mr. MONTGOMERY. Thank you, Mr. Chairman.

I think this is a very timely hearing. That's one reason I wanted to drop by this morning. I agree with your statement that you've just given. The two main areas that I try to focus on in my work with veterans is health care and then the benefits, such as compensation and pension. But health care is our main area, and I congratulate you for having this hearing this morning.

Mr. EVANS. Thank you, Mr. Chairman.

My colleague from Illinois, if he has any opening statement, I now recognize him.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you, Mr. Chairman, and thank you for calling today's hearing.

Next week, the Subcommittee on Hospitals and Health Care will be marking up legislation dealing with health care reform and soon, the full committee will be doing the same. I believe that today's hearing is a crucial and unique step in that process. That's because the discussion that we are having today, focusing on the current perception of the VA health care, gets right to the heart of the matter: The question of how successful the VA can expect to be on their health care reform. We keep hearing that we, as Members of Congress, are on the verge of making a monumental decision. But let's keep in mind where the real decisions about health care will occur, at the individual level. The VA will sink or swim

based on the choices made by each man or woman, each potential user of the system. Let's picture how that will work.

When it comes time for people to choose among their many options, they'll spread out the brochures and pamphlets on their kitchen table. They'll look at last year's medical bills and they will try to imagine what the various programs mean to them. Images and experiences, some more pleasant than others, will pop into their minds. In other words, their decisions will be based on their perception of the various providers. If the VA wishes to compete, it will have to succeed at that very point, at the very instant, when the veteran is faced with the choice of picking or rejecting the VA.

Mr. Chairman, if you will allow me, I would like to cite a specific example of how the VA care is perceived. I have recently been forwarded documents concerning the VA hospital in San Juan, Puerto Rico, including alleged misconduct by staff at that hospital. The charges of mistreatment are dramatic and severe ones and unflattering at best and potentially damaging at worst. For that reason, I have forwarded them to Secretary Jesse Brown for a full and speedy investigation. I appreciate the willingness expressed by the Secretary regarding my request.

Mr. Chairman, I am also providing copies of this material to the staff of your committee for their reference.

Whether or not these allegations are true—and I must trust that this remains left to be seen—the fact remains that the perception itself does exist. For years, veterans in Puerto Rico have made their feelings known. They have felt that their care provided to them is not on the par with other veterans. They certainly do not feel that the service provided to them accurately reflects the service that they gave to this country. And while I am not ready to say that such allegations are true or false, I will say that they are made more credible because of the variety of complaints that we have heard for years. These complaints state that the VA in San Juan, like too many other facilities, is one of long waits and short supplies.

Mr. Chairman, veterans deserve to feel confident that when they enter a VA hospital, they are receiving the highest quality care available. After all, a certain level of competence and comfort is essential to the health of a patient. And once again, we come back to perception because it is on perception that such confidence will be based. That is why I am very appreciate to you and your staff, Mr. Chairman, for calling this hearing. And I am also appreciative that you have another aim of this hearing, to identify those changes that need to be made under reform.

If veterans learn about this hearing, they can gain some measure of confidence that we, those who oversee the VA, are willing to take action on these items. I pledge to work with you and the Members who share our commitment to ensure that such changes take place. Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

The Gentleman from Massachusetts.

OPENING STATEMENT OF HON. JOSEPH P. KENNEDY II

Mr. KENNEDY. Yes, Mr. Chairman, I think this is a very important and timely hearing. I, just last week, convened a meeting of

all the health care providers throughout Massachusetts and most of New England, to talk with them about their feelings health care reform and how it might affect the VA.

One of the issues that became clear is the sense of a need of a mission for VA health care providers. Chairman Montgomery has done an excellent job in terms of trying to attract as much money in a very tight budget situation, and has provided for an excellent research program with regard to spinal cord, prosthesis and other areas of expertise. But what came across to me was the sense that the VA is not going to be all things to all people. That it's going to have a very difficult time making a transition if it is to provide 100 percent of all the health care needs of the veterans that it is currently serving.

That, in fact, there is a major problem in this country today. Women make most of the choices on which health care plan is going to be utilized by a family. There are very few women's services available in the health care system. And so, as a result, if everybody's wife is out there deciding which health care program they're going to join, it might be a long day before the family is then attracted as a result of the woman making the choice.

Secondly, the notion that many people, I think, are banking on, that the VA simply, by providing free care to poor veterans and service-connected veterans, is going to be this great magnet to draw people into the system is also problematic because under many of the health care choices that are being made available in the Congress today—being discussed in the Congress—those particular veterans will be able to get that free care no matter which health care provider they choose to go to.

So, you're basically banking on the system working, simply because veterans want to hang with other veterans when they go into a health care facility. Now, that might be true for an older group of veterans, but I think a younger group of veterans might be less concerned about going into simply a veterans' facility, and might be more concerned about other issues.

So, I think that there are some serious challenges that need to be faced by the VA. And I think that this is an excellent beginning to discuss, in a very open manner, I hope, the kinds of choices and difficulties that are going to be faced and recognizing that the notion—finally speaking, the notion that there's going to be this great double dip, that somehow Chairman Montgomery is going to be able to get $4.5 billion or $4.1 billion, or whatever that number is—$4.1 billion as a direct new investment.

In addition, you're going to get free care for all veterans, you know, the service-connected and low income veterans and that you're also going to then get reimbursed by an alliance or whatever, HCFA or whomever else stands between the government reimbursement system and the health care deliverer. In addition, that we're going to be able to fully protect the $16 billion health care fund that currently goes into the system is just hogwash. It isn't going to happen like that.

So, I think that there are some unrealistic expectations that are currently, you know, on sort of the hopeful side of the equation. I think the sooner that we begin to deal with the reality of what is going to take place, the better off everybody is going to be.

I finally want to just thank Chairman Montgomery for taking the initiative that he has done in terms of trying to establish a basis for an entitlement program for veterans. I think that is a very smart political step forward. But I think that in this environment, it's also going to be very difficult to achieve all of the goals that the chairman has set out.

And so, I look forward to working with you, Chairman Evans and Chairman Montgomery, in terms of trying to deal with some of the complicated issues that I think the veterans system is going to face in the next few months, to be honest with you.

Thank you very much, Mr. Chairman.

Mr. EVANS. Thank you for those issues you've raised. They're important ones and we need to address them.

The first witness this morning is David Baine, Director of Federal Health Care Delivery Issues, Health, Education, and Human Services Division, U.S. General Accounting Office. He's accompanied by Jim Linz, Assistant Director of Health, Education, and Human Services Division, and Sibyl Tilson, Senior Evaluator.

Dave, obviously, you know how to do this. Your entire statement will be made part of the record. I understand you have some tape recorded portions of your testimony, so we'll let you proceed at this point.

STATEMENT OF DAVID P. BAINE, DIRECTOR, FEDERAL HEALTH CARE DELIVERY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY JAMES R. LINZ, ASSISTANT DIRECTOR, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION; SIBYL TILSON, SENIOR EVALUATOR

Mr. BAINE. Thank you, Mr. Chairman.

Good morning and thank you to all members of the subcommittee for inviting us to discuss veterans' perceptions of the current veterans health care system and their opinions about the future role of VA under health care reform. Our testimony today will be based on preliminary results of a series of focus groups that we held with veterans across the country. We held these focus groups at your request, Mr. Chairman.

Focus groups are basically small groups of people who get together to talk about a given topic, in this case, veterans' health care. These groups provide a range of views on a topic, but the results can not be quantified and are not necessarily representative of the population as a whole. We met with both veterans who currently use VA or have used VA within the last 3 years, and veterans who do not use VA facilities. A total of 127 veterans participated in 14 focus groups we held in Baltimore, Charlotte, Denver, San Francisco, and Martinsburg, West Virginia.

In summary, the views of the participants were as diverse as the veteran population itself. While the views expressed were varied and may not be representative of the veteran population as a whole, several themes seemed to us to have emerged. The first of these is that veterans, other than those without health insurance, seem to use VA only for certain services such as the treatment of service-connected disabilities, rather than relying on VA for all their care. This fact has important implications for health reform

because such veterans would be required under the proposed Health Security Act to choose either VA or another health plan to provide all of their comprehensive health care benefits.

Veterans' satisfaction with VA care varied by location, but focused mainly on poor customer service. The reputation of individual facilities will likely be a significant factor in determining whether veterans stay with VA under health care reform.

Focusing exclusively on customer service issues may ignore another important set of concerns. Veterans perceive that the care offered by VA can be erratic. Whether groundless or not, veterans' misgivings about the quality of care rendered will affect VA's ability to compete in a reformed health care system.

Apprehension about change was a recurrent theme running through the focus groups. Veterans expressed concern that changes would diminish or eliminate veterans' health benefits, that allowing dependents to use VA could detract from care for veterans themselves, that VA would lose its individuality and its focus on the special health care needs of veterans, and that veterans who are dependent on VA would be hurt emotionally.

Other veterans did not see a need to maintain separate veterans' health care facilities as long as veterans were given a viable alternative. The primary concern of this group was that veterans be given something of value equal to what they have now.

Veterans frequently indicated that the health care needs of veterans with the most serious service-connected disabilities should be the VA's highest priority. Veterans with PTSD, spinal cord injuries, illnesses possibly related to exposure to Agent Orange, or illnesses possibly related to service during Operation Desert Storm were cited as deserving special attention.

At this point, as you mentioned, Mr. Chairman, I'd like to depart from our usual way of presenting testimony and present for the subcommittee, a tape that we have put together which contains excerpts. It's about a 14 minute tape. It contains excerpts from the 28 hours of focus groups we held across the country. The sound quality of the some of the clips that you are about to hear on the tape varies somewhat. For some sound clips, there's extensive background noise or several veterans talking at once, as you would expect in a group setting.

We tried, to the maximum extent possible, to use the actual sound clips from the focus groups and from the veterans themselves. On four of the clips, the background noise became too distracting when amplified through this sound system. So, for the purposes of this hearing, we re-recorded those four clips using our staff. Our staff read the exact words of the veterans who participated in the groups. We would like, however, with your permission, to provide a tape containing the actual voices of the veterans to the committee, to be made part of the record.

Mr. EVANS. Without objection, so ordered.

Mr. BAINE. If we could try the tape now, we're all anxious to see how this is going to go.

Mr. EVANS. All right. Please proceed.

[TAPE PLAYED.]

GAO COMMENTATOR. Why do you choose to get health care from VA?

"Well, I'll tell you, I don't have any insurance at all, nothing. That's the only hospital I've got to go to for anything."

"I'm the same way."

"I mean, whether it's service-connected or if I get sick or hit by a car, that's the only place to go. I'm homeless, unemployed."

"I use the VA as a safety net. If I am working and if I am covered with insurance, I will not use the VA; I will use my private insurance. But if I become unemployed, that's my safety net by going to the VA hospital."

"The only thing I use the VA for is strictly on the things that were service-connected. I don't use them for anything else. I have my own private doctor outside of the VA for all other medical purposes."

"It's the VA's responsibility to take care of those injuries that you received in the war, not your insurance company's."

"I'm not going to take my problem to somebody else when the military, VA, is responsible for it. You're going to see me today, or you're going to see me every day for the next six months, whatever it may take, because it's your responsibility."

GAO COMMENTATOR. How would you describe the veterans' health care system in one or two words?

"Caring and hopeful."

"They're big and slow."

"I would say dedicated and helpful."

"Time-consuming."

"Good service."

"It's expensive to the government."

"They're uncaring and case hardened."

"Very slow and no offense, an old folk's home."

"Administratively bogged."

"Difficult and overcrowded."

"Getting better."

"A lot of government bureaucracy."

"I think they're under-funded also."

"Secretive."

GAO COMMENTATOR. Are you satisfied with the care you get from VA?

"The main thing is you have to wait. You have to wait. I used to get mad, but then it dawned on me, hey, this is free."

"It seems to me like they do research on the veterans, and then the good from it goes somewhere else, and then they raise your insurance policy premiums."

"One thing that I dislike about the Veterans' Administration, the whole system, is they reward you for not getting better. If I don't get better, I've got free medical for the rest of my life. If I get worse, I get more money every month. Is that a real incentive to get better? Not at all."

"What we need as older women are glasses, not service-connected; dentures, not service-connected; feet with corns and bun-

ions and things like that, not service-connected. So, the things that we need as older women are not available to us."

"I'm happy and I'm satisfied. I've been in the system. I'm 100 percent through the VA. I get 100 percent. I've used their system since 1978. You have to wait a long time but I'm just happy that I'm seen. I've just had a good experience, you know."

"I've been in VA hospitals all over. I went up to Salisbury three times. I took my card and threw it on the desk and told them I will never come back in that hospital again. I go to Columbia all the time. I was in the VA facility at Audie Murphy in San Antonio, Texas. I was in the VA facility, Carl Henson, down in Dublin, Georgia, and I have never seen anything like that mess up there in that place. They need to close that hospital. Or go in there and fire everybody in there and put somebody in there that will run that hospital and treat those veterans like they need to be treated."

"The attitudes as far as being in a new facility. I put it to the people like this: whether it's a new facility or the old facility, you've got the same jackrabbits running through there. So, what was down in Lock Raven is definitely up at the new hospital."

GAO COMMENTATOR. How would you describe the customer service at VA?

"Down in Washington, you pretty much have to wait on yourself, making your own beds and everything. Because I've been there—well, I've been there months at a time and pretty much had to take care of myself, make my own beds. They bring the sheets and lay them there and if you didn't make it, it wouldn't get made."

"They treat you like you're a charity patient. When I walk in there, I don't want to be ignored. I want to be treated like I'm a human being. They are there because I have to be there. If I don't have to be there, then they have no jobs."

"They try to make it as difficult for you as possible. They have lost the attitude of service. You are just a number."

GAO COMMENTATOR. How convenient is it to obtain care from VA?

"If you go down there without an appointment, you can wait all day. You might have to wait until some time at night just to see a doctor."

"Out at VA, you go to one place and sit there for 20 minutes reading the newspaper. You move down to another spot for 20 minutes reading the newspaper. Pretty soon, you almost miss lunch and you feel like leaving. I don't know. I don't understand why it has to be that way."

"There's no parking, period. You park 20 miles away, walk over, then get your appointment made."

"Well, that's why everybody is there early. A lot of people are there early just so they can park."

"I see it all the time. People have to drop them off, then go park the car and come back. You know, sometimes almost an hour, there's this poor guy sitting in a wheel chair, you know."

GAO COMMENTATOR. Do veterans need a separate VA system?

"There are things that happen in a war that don't happen any place else. And if you don't have a VA facility to take care of those veterans, you send them into the general public hospital. They won't have any idea of what to do."

"I really think they could better serve the veteran if they would abolish all the hospitals, tear them down, get rid of all the overhead. You can't imagine how much money they spend all over the country every year to operate the VA. Just take that money and put the guys in a regular private hospital."

"What we're saying is that the VA would become an insurance. Instead of giving service, they will provide the payment for the service. They would administer the insurance portion of it. They wouldn't be the care giver."

"If you eliminate all the VA hospitals, you have to give veterans that have to use them viable alternatives."

"My belief is that they could give them better care, because they would have more money."

"And certainly the guy would have a more cheerful atmosphere in a private hospital than you would in a VA hospital."

"I see nothing wrong with being incorporated into one big deal, as long as I got the same value I get now."

"If we take the VA away, what else is next? They're trying to lump us all in with everybody now that never went to war, never got hurt. I feel like you keep the veterans' benefits separate. If they don't, we're going to lose them."

GAO COMMENTATOR. Should VA offer care for veterans' dependents?

"If you are saying, well, you're going to have to make one decision, are you saying we make that one decision just for our personal needs? Or are we making them for our family's needs? Because for our family's needs, if it's our family's needs, bye-bye VA because I've got to take care of my family."

"I have no problem with the VA taking care of families, but I don't want to see it at the expense of the veterans who earned it either."

"They're going to be offering well-baby clinics. Is that going to detract from someone getting in for a neurological problem? I'm uncomfortable with that."

"I can't see my wife going to the VA hospital, period. And I can't see the kids going."

"There's a lot of things in the VA hospital I wouldn't bring my kids in to see. I mean it would totally—you know, we'd walk in the door and then all of a sudden, you've got about three or four people screaming at the top of their lungs or talking to themselves."

"It's like going into a bad Greyhound station."

"The VA was created to take care of the individuals who bore the brunt of the battle, not for my wife, not for my kids."

GAO COMMENTATOR. Under one health reform proposal, all citizens will be able to choose a health plan in their area. Veterans will have one additional option in that they will be able to select VA as their health plan. Veterans, like other citizens, may be restricted to using one health plan exclusively. As a result, veterans may no longer be able to pick and choose among their different insurance plans.

Should VA set up managed care plans to compete with the private sector?

"I would not go to the VA if it became like an ordinary place, a one-size-fits-all institution."

"VA's going to be in the same business with an advertising budget, marketers and the whole bit. Is that where we want VA to go? They were not set up to compete with a private HMO company. If they start doing that, does that dilute what they were chartered to do when they were established, which was take care of disabled veterans? I don't know that they should be competing."

"I don't know that the veterans wouldn't get lost in the shuffle or the bottom line."

"People made sacrifices, commitments, and did things based on a certain level of understanding. And if you're going to change it, okay. That's certainly the Congress' right to change it. But they shouldn't change the deal they already cut with people in this room."

"That would be a couple more billion dollars thrown in the trash can. But it's a big black hole. It's a lot of money thrown down the drain. I'm sure that they could—I wonder what the studies say, but I'll bet that if they just paid the insurance premium on each veteran that went to the VA hospitals, they would have a cost savings, a measurable cost savings."

"And now we're turning them into just another doctor schlepp outfit. I mean, they're out there schlepping for more patients so that they can dilute what some of these guys need."

"I also say that I don't want to give away what I have. I would like to see the VA stay the way it is."

"I don't even think it should be an option. It's an entitlement. You should have an option of going to the regular insurance plan everybody else has, and you should also have the entitlement of going to the VA if you so choose."

GAO COMMENTATOR. Could VA effectively compete with private sector plans?

"I think that would be a lost cause."

"If Lee Iaccoca can take the Chrysler name that was in the toilet and bring it back up, then they can do the same thing with VA."

"I think it is logical to conclude that the Veterans' Administration doesn't really have a reason to exist in terms of cost benefit. I would have to think seriously about whether or not eliminating the Veterans' Administration health care also eliminates the symbol of responsibility to veterans who had service-connected problems. In balance, I don't know which way I would go. I know which way is logical, but the country is run on politics. Eliminating the symbol possibly is dangerous, so I don't know."

"I still think there are a lot of veterans that are probably inefficiently warehoused in veterans' hospitals that are there permanently. Where are they going to go?"

"I think emotionally it would hurt one group—a group of veterans that have been dependent on that. That's their security, and I think it would be devastating to those people that have been using VA all along."

GAO COMMENTATOR. What factors would you consider in selecting VA for your health care?

"A lot of people are going to look into reputation. A lot of people who have already been to the VA, to the bad ones in particular, are going to take into consideration how they were treated at the VA before. They're going to think about this. They're going to say, do

I want to go back to that same damn system again? No. They're going to say no."

"The VA hospitals are in sympathy with our particular needs. If we went to outside providers, we would have to start from scratch to explain to them what our particular problems are. I think we need to maintain the veterans' hospitals."

"I really think that you guys need to look at the connection between politics and what happens with Congress and to the VA hospital. When they say, cut the budget, what ends up happening? The question really is related to disconnecting veterans' care from the whims of politicians."

GAO COMMENTATOR. If you were Secretary of VA, how would you change VA to compete in health care reform?

"He's got to sell the idea. He's got to market the whole thing. He's got to attract good doctors, and then tell the people that are out there, we've got great doctors. Then bring in the people. Anything a business would do—what would Kaiser do? He should ask himself every day, what would Kaiser do? What would Cigna do? What would anybody else do that's in the business?"

"To streamline the outpatient system. I think that that's where they're really overloaded is the outpatient clinics."

"For the VA to get into contention as a runner in this business of providing health care to the people out there, it's going to have to improve its image."

"I'd like to see every one of those people fired."

"I would certainly allow autonomy. For example, if in Prescott, Arizona, their VA had all rural people far away, I would try and develop some kind of service that I could get out to those people. If I'm in downtown San Francisco or someplace where, you know—I think in Seattle, they have one downtown. Maybe there is a different kind of service I'd provide, but I'm trying to make sure that my local administrations have some kind of autonomy to service their populations, the demographics or whatever they have to deal with."

The VA hospital here has a good reputation. Other VA hospitals don't have such good reputations, yet they're all in the same plan. Somebody really should get around and look at them all and say, you know, this is good. What you've got stinks and get rid of it. Mimic this better and do more like this."

Mr. BAINE. As you can tell from the recording, Mr. Chairman, the veterans expressed a wide range of views about the most appropriate role for VA under health reform and about the care provided by VA facilities around the country. While their views may not be representative of the Nation's 27 million veterans, many of the concerns expressed—such as excessive waiting times and poor customer service—have been the focus of prior GAO reports and hearings held by both this subcommittee and others. VA should consider such improvements as a necessary ingredient for competing successfully in a reformed health care system.

My collcagues and I would be more than happy to try to answer your questions.

[The prepared statement of Mr. Baine appears on p. 107.]

Mr. EVANS. All right, Dave, thank you very much. I thought that worked out very well, and I'm glad you were able to work out the

bugs in the system. It really did present the array of opinions that veterans have about the VA health care system.

Mr. BAINE. I have to admit that we were a little nervous about this, going in.

Mr. EVANS. Could you generalize—I know you've got 28 hours of these focus group sessions—about what is most important to veterans and what has GAO concluded from veterans' perceptions of VA health care and health care reform?

Mr. BAINE. What is most important to veterans, Mr. Chairman?

What many veterans told us was most important to them was the fact that they can get medical service for their particular disabilities. And with regard to their perceptions, I think it varied as you heard on the tape. They're interested in customer service. They're interested in being able to go to a VA facility and being treated as they would be treated if they were to go to a private sector provider. Those seemed to me to be the most important perceptions.

Maybe Jim would——

Mr. LINZ. I wouldn't want to leave you with the impression that there were no negative comments about the private sector because there were. In some groups there were negative comments about Kaiser, about HMOs in general. There were some veterans that were very positive about customer service and VA, particularly those in Martinsburg, West Virginia. They seem to like that facility. We went to Baltimore expecting to get very favorable reactions since they had the brand new facility, and were surprised to get more negative responses.

But I think Dave is right that the main thing they seem to want is timely care and a caring attitude.

Mr. EVANS. GAO previously reported that as many as 47 percent of VA's patients might choose another health care provider under health care reform. Has GAO changed its assessment? Would these tapes reinforce your assessment?

Mr. BAINE. The 47 percent number that you referred to, I believe, was in a report we did 2 or 3 years ago. In doing that report and making that projection, we based our projection on certain assumptions, Mr. Chairman. Those assumptions were that the benefit structure in whatever national health reform plan that would be developed would be roughly equal to the benefit structure at the VA. Or vice-versa, that the VA's benefit structure would be roughly equal to that one.

We think that the 47 percent number is accurate if that were to be the case. As you know, under the President's Health Security Act, the benefit structure for the VA is much more generous than the comprehensive benefit package under the proposed Act. So, ultimately, the number of veterans who chose VA may be largely a function of the benefit package that is negotiated under health reform relative to the benefit structure under the VA plan.

Mr. EVANS. I think it might be useful for VA employees, perhaps system-wide, to listen to this 14 minute focus group tape. I understand that some San Francisco VA Medical Center employees observed at least one discussion session in San Francisco.

Mr. BAINE. That's correct.

Mr. EVANS. What did these employees learn about veterans' perceptions and how did they react?

Mr. BAINE. I believe that the employees, if I remember correctly, were from the Women's Health Clinic in San Francisco. Sibyl Tilson can talk a little about why they joined to listen and give you some reaction to that.

Ms. TILSON. The VA employees were actually the coordinators for women's health from the regional office in Oakland. They heard that there needs to be better internal communications within VA because some of the users of the orthopedics clinic—the doctors that were treating the women veterans there didn't know that a women's clinic existed. So, they need to do internal marketing within the VA Medical Center itself.

We heard from the non-users that a lot of military hospitals and public health hospitals are closing in the San Francisco area. Many of the non users were interested in the women's clinic that people in the group perceived favorably. The VA employees were happy to hear that there was a potential group of veterans that might well be interested in VA.

Mr. EVANS. The gentleman from Illinois.

Mr. GUTIERREZ. Thank you very much.

Mr. Baine, I think that you hit the nail on the head in your prepared statement, and you were exactly right when you said, "whether groundless or not, veterans' misgivings about the quality of care rendered will affect VA's ability to compete in a reform system."

I think you're exactly correct. The question of whether these feelings are based completely or solely on fact is not so important. The important thing is whether or not that perception exists. Basically, I want to ask you what kind of challenge that presents to the VA in terms of how extreme reform should be? Do you think the VA has dug itself into a hole that is too deep to get out of? Probably some of your people in your survey said that to you. Or are expectations so low that almost any real change made by the VA will have a huge positive impact?

Mr. BAINE. I think our impression is, Congressman, that as VA tries to develop its plans for competing under health reform, it needs to think very carefully about what it does best and what it does not do so well, and what the competition is going to do.

The perception that you raised, I think is very true. The perception of the VA—or veterans' perception of the VA does vary by location. The people in Martinsburg thought they were getting great customer service, thought the people who worked in VA were great, and that everything was fine. And the veterans were coming from quite far distances to go to that facility because they had heard that everything in that VA was fine and they believed it. Veterans in other areas with different facilities were not quite as satisfied and they had heard that the services in those facilities were not quite as good.

So, I believe that as VA develops its plans, it's going to have to think very carefully about what it does best, where it does it best, and to do some of the things, as you heard on the last clip of the tape, to mimic—I think the man's words were— the things that work and to really get rid of the things that don't.

Mr. GUTIERREZ. You heard in my opening statement that I am concerned about a situation at the VA facility in San Juan, Puerto Rico, and I don't want to get into the specifics of that case in the moment. As I said earlier, the facts still need to be verified.

However, I would like to expand on something in the testimony you submitted. You said that veterans' level of satisfaction with the VA varied based on several factors including location. I am wondering to what degree a veteran in one city might have a view of the VA that is different from opinions expressed in another city. In other words, is it possible for veterans at one facility to legitimately complain about abuses or mistreatment at one VA hospital even if such allegations are not raised by veterans at other sites? Or should the problem show up throughout the system if they are to be considered valid?

Mr. BAINE. My answer to that would be partially a repeat of what I mentioned before. VA's reputation does vary by location. So that veterans in some particular locations—as you might have heard on the tape—the fellow that was talking about facilities in San Francisco and Seattle—some of that information was anecdotal, I believe, based on stories that person had heard from his friends about the reputation of a different VA facility. The stories may or may not be true, but they shape veterans' perceptions of VA.

The other thing I would say about the perception of the quality of care is that veterans' perceptions are not really based on the Joint Commission's Accreditation of rating of VA hospitals and VA's high scores. Veterans' perceptions are shaped by what happens when they show up at the place. The reputation of the VA is based on their treatment and their buddies' treatment rather than the statistical things that we all talk about.

Mr. GUTIERREZ. But a group of veterans at a particular institution can say, "you know, things are really bad here." And just because you don't find it duplicated throughout the system doesn't mean that that's not happening at that particular place?

I guess my point is that some people say, "well, that's not true because we have all these other examples of fine treatment."

Mr. BAINE. Right.

Mr. GUTIERREZ. But it's not equal, is it? The VA system is not equal throughout the country?

Mr. BAINE. By no means is VA the same across the country. When we look at any issue we find that when you've seen that activity at one VA facility, you've seen that activity at one VA facility. So, it's very, very difficult to generalize from any particular finding either bad or good, positive or negative, as happening in other VA facilities across the country. And I think our appearances before this subcommittee have reinforced that over and over and over again, over the years.

Mr. GUTIERREZ. Thank you, Mr. Baine.

Mr. BAINE. You're welcome.

Mr. EVANS. The gentleman from Washington.

Mr. KREIDLER. Thank you, Mr. Chairman.

Out of curiosity from your focus groups, could you get any assessment as to the depth of feeling of allegiance to the VA system that

puts some weight to the sense that yes, we want to have the VA around as opposed to having alternatives, or whatever it might be?

Mr. BAINE. Let me respond briefly and then I'd like Jim and Sibyl to discuss that further.

I think, as you heard on the tape, that the feelings vary and the depth of the emotion varied considerably. There were some people that reacted very positively to the VA and were vehemently positive. On the other hand, there were some comments that were quite negative.

Let me ask Jim to elaborate on that.

Mr. LINZ. I think one of the populations that's going to be the hardest for VA to retain are those veterans that are using a combination of VA and Medicare or VA and private insurance. They're going to have to choose either to get all of their care from VA or all of their care from the private sector. And there's not really good evidence out there as to what extent they're using VA versus the private sector now that would really give you an inclination of which way they're leaning.

We did get a number of veterans in the focus groups that said they only used VA for treatment of their service-connected disability. And if those people are using private care or Medicare for most of their care, I would kind of assume they would lean towards choosing a private sector plan.

Mr. KREIDLER. Do you get a sense that their decisions are somewhat driven by economic factors? That is if there's some care in the VA where they can get it there without any out-of-pocket expenses, as opposed to what it would be trying to turn to their private physician.

Mr. LINZ. I think that's clearly a motivation for certain services. I think some veterans clearly come to VA for services that aren't covered under Medicare. They come to VA for prescription drugs, hearing aids and eyeglasses that aren't covered under Medicare. They may come to VA for treatment of service-connected disabilities because their private insurance has an exclusionary clause in it.

Mr. BAINE. One of the things that we're doing right now, Congressman, is trying to get a handle on that very question for veterans who obtain some of their services, for example under Medicare. What we're trying to do is to isolate the kinds of services that they are also being provided by VA so that we can give you folks some information about that very issue.

Mr. KREIDLER. I think one of the questions that probably raises its head—and this is somewhat of an emotional issue—but how much does the average veteran who is eligible for benefits out there care whether their treatment is provided by private physicians or whether by the VA? Or is a lot of the emotion that we often hear and is much more public, coming from the VSOs who have a very strong feeling that the VA needs to be maintained?

I'm just trying to get some relative kind of sense of what is true for the average eligible veteran, if you can have some assessment, as opposed to might be coming from organizational leadership.

Mr. LINZ. I think there clearly were a number of veterans in our focus groups that believe there is a definite need to preserve the separate VA facility. They're not interested in being put in a main-

stream health plan. They firmly believe that the VA treats patients differently. The VA understands their health care needs. And the VA system needs to be preserved.

On the other extreme, there were veterans in the focus groups that talk about doing away with the separate VA system.

Mr. KREIDLER. I'm curious because of listening to the tape here and your own description of it, about the amount of confusion out there as to what reform really represents. Do you think that's been one of the stumbling blocks for perhaps seeing a stronger advocacy of reform taking place because of that confusion?

Mr. BAINE. My sense is that that is very much the case. There's a lot of uncertainty—we heard a lot of uncertainty about what the National Health Reform Plan is going to look like, and also, a lot of uncertainty about where VA was going to fit in that reformed health system. The basic question was: What are going to be my benefits under any kind of a reform proposal and under the VA plan?

There's a lot of uncertainty and a lot of apprehension about change. Both these folks, and some of us, are confused about what health reform may mean.

Mr. KREIDLER. Perhaps a reflection of general societal perception. It's no different for the VA.

Mr. BAINE. Right.

Mr. KREIDLER. Thank you very much, Mr. Chairman.

Mr. EVANS. You raise a good point, Mr. Kreidler. I heard that myself. Veterans are very concerned about what the future may bring. We need to really sell the program if we're going to get it passed, or make it viable for veterans.

The gentleman from California.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Just a brief comment. Again, I think we've touched on something that we have to decide as a veterans' committee, working with the VA.

There is a real paradox with respect to viewpoints. On the one hand, there's a lot of dissatisfaction with the system. But on the other hand, people are scared of what a competitive system means. You've got that paradox of discomfort with an existing system, but a real fear of losing the mission, losing what the veterans are supposed to be in a competitive system. For example, what does "marketing" mean for a public agency?

We need to resolve that. That's what I heard. It's not a question, but just a feeling I have.

Mr. BAINE. I think you're absolutely right. There are two aspects to your comment. One has to do with the kinds of services that are being provided in VA now and this subcommittee and a lot of other subcommittees have addressed many of the operational aspects of the VA system as it exists now.

But there is a paradox because these people are not quite sure how health reform is going to affect the VA or affect them.

Mr. EVANS. Yield to the gentleman from Illinois.

Mr. GUTIERREZ. Thank you, Mr. Chairman.

Mr. Baine, how did you get these folks together, these veterans together? I mean, did you post that there would be a focus group

meeting and whoever wanted to come? How did you pick these folks?

Mr. BAINE. Sibyl can walk you through the details of this. But basically, what we tried to do was to pick categories of veterans, service-connected, low-income, higher income, Medicare-eligible, groups of women veterans, veterans who lived more than 40 miles away from a facility so we could talk about distance factors and those kinds of things. And we tried to do it in geographic locations around the country.

Then we made hundreds and hundreds of phone calls to try to ask these people if they would like to participate in the focus groups.

Mr. GUTIERREZ. So, you called them up? After you figured out where they were at, you called them up and said——

Mr. BAINE. Yes.

Ms. TILSON. Yes, we had their names and addresses and looked up their phone numbers and telephoned them. For instance, for the two meetings in Baltimore, we made over 300 phone calls, just going down the list. We did the calling at night so we'd try to get a representative sample of people within each category of veteran. We offered veterans travel money, so they would have some sort of compensation for the effort of getting to the meeting.

We held most of the meetings at 5 o'clock and at 8 o'clock. Five o'clock in the afternoon, 8 o'clock at night, so we could get a working population to attend. Both of the womens' groups were held at 5 o'clock in San Francisco so they would be comfortable attending the meetings. And for the Medicare-eligible population, we held it at 10 o'clock in the morning and 2 o'clock in the afternoon, so elderly people would be willing to participate.

Mr. GUTIERREZ. Thank you.

Mr. BAINE. This was a very interesting exercise for us. We had never tried anything like this before, but I think it worked out reasonably well.

Mr. GUTIERREZ. Thank you, Mr. Chairman, for allowing me——

Mr. EVANS. Some of us politicians are interested in knowing how well you did this.

Mr. BAINE. I'm sorry, sir?

Mr. EVANS. Some of us politicians are interested in knowing how you did this exercise. Thank you, gentlemen.

Mr. BAINE. We learned a lot as we went.

Mr. EVANS. Off the direct topic, I'd like to know what improvements has VA made since GAO testified before the subcommittee on the long waitings and access problems veterans face for outpatient care?

Mr. BAINE. The short answer, Mr. Chairman, is that we have not gone back at the facilities to find that out. We'd be glad to do that, and hope to do that in the not-too-distant future.

The VA has, in fact, issued regulations and guidelines as a result of our work. Dr. Headley's testimony that I read this morning seemed to indicate that the VA has taken to heart some of the customer service issues that were raised. I don't think there's any question that if the VA is going to be a competing provider under any kind of a reform plan, it's going to have to, as you mentioned in your opening statement, take the big ship and turn it around.

You know, VA has been, essentially, an inpatient based system, offering episodic care, rather than managing veterans' health. They're going to have to turn this around. I happen to think that the things we talked about at the previous hearings were right on target. Because if VA does not change, I don't see any way that the VA can compete in a reformed health care system. But more importantly, the veteran population are not getting the services they should be getting as the system is right now.

Mr. EVANS. Any other questions from any other Members? (No response.)

Thank you, Dave, and thank your staff for the excellent testimony. We appreciate it. It has been very helpful.

Mr. BAINE. Thank you.

Mr. EVANS. Thank you. The members of our next witness panel represent veterans' service organizations. John Vitikacs is Assistant Director, National Veterans Affairs & Rehabilitation Commission of the American Legion. AMVETS is represented by Michael Brinck, National Legislative Director. Terry Grandison is Associate Legislative Director of Paralyzed Veterans of America and Dennis Cullinan is Deputy Director, National Legislative Service, Veterans of Foreign Wars.

Your statements all will be included as part of the record.

John, we'll start with you when you're ready.

STATEMENTS OF JOHN R. VITIKACS, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; MICHAEL F. BRINCK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND DENNIS CULLINAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE U.S.

STATEMENT OF JOHN R. VITIKACS

Mr. VITIKACS. Mr. Chairman and members of the subcommittee, good morning. The American Legion appreciates the opportunity to comment on the subject of Veterans' Perceptions of VA Health Care.

Mr. Chairman, we request that our summary comments be included with our written testimony in the full text of today's hearing.

Mr. EVANS. Without objection, so ordered.

Mr. VITIKACS. Mr. Chairman, results of VA's fiscal year 1993 patient satisfaction survey indicates that veterans consistently rate the care received in VA in a favorable manner. Of the 900,000 hospital discharges comprising the acute inpatient care survey for FY 1993, 97.2 percent of the respondents rated VA care as fair, good, or very good. The VA outpatient care survey of nearly 124,000 veterans show that over 96 percent of the respondents rated the care received as fair, good, or very good. The intermediate and nursing home care survey reported a response rate of 96.2 percent for care received as fair, good, or very good. All three surveys recorded the majority of responses in the good and very good categories.

Since the inception of this survey process in fiscal year 1991, the overall positive response rate for each of the three major hospital programs, hospital, outpatient and extended care has averaged at least 94 percent.

Mr. Chairman, in our prepared statement for today's hearing, the American Legion states that VA operates a first-rate medical care system, limited only by constrained resources. We understand that on occasion, an event occurs which tarnishes VA's public image. However, on the whole, we have consistently maintained that the medical care provided by VA is of high quality. VA's Office of Quality Management has been able to provide reliable feedback from patients to support this point of view.

This subcommittee is fully aware of the position of the American Legion with regard to VA's future role under the President's health reform initiative and the potential impact of the National Performance Review, Employee Reductions on VA Health Care. We believe that many of the answers we all seek concerning VA's ability to sustain an adequate marketshare of veteran patients under health care reform will depend on the many efforts now taking place.

Mr. Chairman, veterans care about the same issues as all Americans when it comes to making health care decisions. These include quality of care, convenience, professional courtesy, cost, timeliness of care, and other like factors. A market survey of current and former VA users, as well as veterans that have never used VA, was recently conducted. The customer survey was sanctioned by VA's Health Care Reform Project Office, NOMB. It is our understanding that a more comprehensive baseline study on potential market demand for VA health care services will be conducted this summer.

Based upon results of the market research study, it is interesting to note that those veterans who are most familiar with VA through direct experience are more favorable toward using VA under a VA health plan option within health care reform, than those who will make a decision based only on perceptions. The survey notes that the veteran market potential under VA health are reform includes close to nine million veterans. When veterans' dependents are included, the total market potential of the VA health care plan increases to over 13 million individuals. According to the study, this market potential could increase if a VA health plan is competitively priced in comparison to other private sector plans.

The study indicates that certain factors will influence the actual affect of a VA health plan on veterans' health care decisions. These are, first, the extent and intensity in which competitors market themselves. Second, the extent and competence in which VA markets itself. Third, the pricing of VA plans versus competing plans. Fourth, the actual delivery network. The American Legion has previously testified that each of these components are critical to the success of the VA medical care system under national health care reform.

In addition to legislative and regulatory changes, VA must also undergo a major cultural renaissance. The business posture assumed by VA must be one of dedicated customer service. As in any situation wherein a business relies upon the consumption of their services by others for its continued existence, that consumer is a customer. Truly a veteran first, but a customer as well.

Lastly, Mr. Chairman, the American Legion suggests that the more in-depth market research study planned by VA for this summer should be conducted with an adjusted sampling of women veterans to better inform VA of their views on VA health care services.

Mr. Chairman, that concludes our statement.

Mr. EVANS. Thank you, John.

[The prepared statement of Mr. Vitikacs appears on p. 118.]

STATEMENT OF MICHAEL F. BRINCK

Mr. BRINCK. Good morning, Mr. Chairman. Thanks for asking us to present our views at this hearing.

Unfortunately, quantitative answers to most of your questions will require a polling of our membership and we're going to do that in our July magazine. We'll be happy to share the results of that poll with you when we're finished.

Your first question dealt with what do veterans think about VA health care and how do they compare it with community?

Veterans believe many facets of the VA medical system are generally equal to or better than their community providers. What they want is VA to be a modern, community-based, technically competent and compassionate medical system that understands veterans' health care as their primary mission. Veterans take pride in a well-run VA facility and its contribution to their communities and nation. In short, they view it as their system.

Your second question asked to rate VA relative to community providers for several facets. While those veterans who are able to get into the system appear to be reasonably satisfied, as was just stated by the Legion, with their technical quality of care, there are still major concerns about the bureaucratic red tape, eligibility, distance they have to travel, amenities, and waiting times.

Next, you asked how will veterans respond to health care provider choices brought about by health care reform?

The question of choice is important. AMVETS believes that balancing pure choice with strong incentives to choose a VA health care plan is the best way to insure veterans' health care needs are met in the long-term. It is obvious that much of the American medical system will be forced under managed competition of global budgets, to move sharply away from a traditional fee-for-service method of delivery to a more group-based system, not far removed from the VA model.

Therefore, VA must be empowered by Congress to adopt those parts of the private health care system that appeal to most Americans like community-based providers for primary care needs and family care. AMVETS feels that if VA transitions quickly to a system that is more community-based and sheds itself of the current eligibility rules which limit access, veterans will have a reasonable choice in making their health care provider decisions. We did a preliminary survey and of 150 respondents, 99 supported using local providers as part of the VA system.

You then asked will current users remain with the system, and will non-users return to VA for care?

There have been several studies regarding this question and you've heard the different numbers that were put out by GAO. Ac-

cording to VA statistics, of 2.99 million applications for medical care last year, nearly 2.9 were from mandatory care category veterans. And of those, 1.4 million were from low income veterans. It is obvious that the major percentage of those now getting care in the VA do so because of the cost advantage, or special treatment VA offers. Both mandatory care groups will likely gain broader access to the medical establishment under national health care reform, with the low income portion of that group having the least to gain by staying with the VA.

What is clear though is that VA must get eligibility reform sought by all the service organizations and evolve to a more community-based system. AMVETS is confident that if you build a system that is veteran focused, that provides local access, that treats the veteran's family, that promotes research problems either unique or highly prevalent in the veteran population, the veterans will come to the system.

Why do we advocate so strongly for a community-based system? Survival of VA requires giving as many people as possible a stake in its success. That is why it is necessary to bring VA out of its isolation and integrate VA medicine more effectively with the rest of the national medical establishment, while at the same time retaining VA's dedication to caring for veterans.

A community with a local VA franchise clinic or storefront has a stake in VA medicine. Local medical professionals then have a stake in VA medicine. The local pharmacy then has a stake in VA medicine. The local suppliers then have a stake in VA medicine. And most importantly, with eligibility reform, all local veterans have a stake in VA medicine, not just the few who live close enough to existing medical centers and are mandatory category veterans.

In short, the structure of the VA medical system will have a great deal to do with how many veterans choose the system. If it remains the bureaucratic, red tape-bound system available only to a few, it is probable VA will become merely the source of last resort for those who are unable to afford care elsewhere, or those who need highly specialized care that VA does so well. That model is not an example of a quality full-service medical system.

What about dependents? Under the current eligibility rules, few dependents can get into the VA. Studies have shown that a veteran's spouse has great influence over the choice of health care provider. A VA plan that accommodates dependents would not only create new revenue streams, but would also enlarge the stakeholder population and improve services for female veterans by creating the critical mass required for cost efficient care.

What will the system look like? As we stated earlier, it's likely that private sector will look more like the VA and the VA will, hopefully, begin to look more like the private sector. And the differences when you walk through the door, eventually, should become transparent.

Finally, Mr. Chairman, I have offered you no hard data today, but like the launch of any new product, there are uncertainties that can be answered only once the product hits the shelves. The nation has invested significant, although often insufficient resources in caring for its veterans, and those resources should be

built upon, not junked. We look forward to assisting in providing solutions to reforming the way the nation upholds its commitment.

That completes our testimony.

Mr. EVANS. Thank you, Mike.

[The prepared statement of Mr. Brinck appears on p. 121.]

STATEMENT OF TERRY GRANDISON

Mr. GRANDISON. Good morning, Mr. Chairman and members of the subcommittee. On behalf of the members of the Paralyzed Veterans of America, we appreciate this opportunity to present testimony concerning Veterans' Perceptions of Health Care.

First of all, Mr. Chairman, I want to talk about perceptions. Based upon our analyses, VA appears to be delivering certain services very well and offering comprehensive coverage for services not readily available to veterans in the private sector, particularly specialized services for veterans with spinal cord disfunction.

VA does have its problems, however, not the least of which involves the way it is perceived externally. Perceptions may have ramifications for patient recruitment efforts as VA enters into competition, particularly in recruiting the non-user and lapsed user populations as the VA's own customer survey revealed.

Unfortunately, Mr. Chairman, perception is just as important as reality for any individual making health care decisions. Anecdotal information is more tangible and accessible to many individuals that statistical truth. For example, letting a veteran know that all VA facilities voluntarily either meet or exceed quality standards set forth by the Joint Commission on Accreditation of Health Care Organizations will not be as meaningful as his personal knowledge of the time Uncle Charlie had to wait four hours to be seen in the ophthalmology clinic, or how rude the clerk was the his neighbor Joe went with a slipped disk.

It is also true that most individuals tend to weight service issues, or hotel amenities, more than medical care issues in assessing the quality of care they receive. This is true of veterans and non-veterans alike because laymen are not typically equipped with the type of information they need to make educated choices in health care consumption.

Mr. Chairman, PVA's health policy department conducted two studies on which our testimony is based today. The first is a series of focus groups. This study looked at several cross sections of the veterans community. In our analysis, we included current system users, lapsed users, and veterans who had never used the VA medical system. For example, we talked to female as well as male veterans, Black as well as White, rural as well as urban, service-connected as well as nonservice-connected, and veterans of all ages and combat eras.

The second source we base our testimony on is an in-house survey developed for PVA's membership, that is, veterans with spinal cord dysfunction, to examine their health care preferences. This membership survey polled 1,200 of our members between November 5th and December 31, 1993. Our studies reveal by-and-large, that PVA members appreciate the services VA provides them. Both the focus groups and membership survey identified a great deal of

satisfaction with VA services received. Obviously, this response was not universal, it varies, particularly from facility-to-facility.

From the focus groups, however, it is apparent that our members are grateful that there is a resource available to them that understands the specific needs of patients with spinal cord dysfunction, and addresses these needs in a comprehensive way. Conversely, complaints from veterans with spinal cord dysfunction are primarily in the areas of service and accessibility. Their complaints were not trivial, particularly in their concern for accessibility to a provider who understands how to treat a spinal cord injured person.

Some of our members protested that they were subjected to care from providers who knew virtually nothing about spinal cord injury, particularly in facilities without spinal cord injury centers. Other members claimed their centers knew out to treat injuries, but that it was extremely difficult to access the care because of cutbacks in clinic hours and staff. Even with these complaints, the consensus of all of the groups consisting of veterans with spinal cord dysfunction could find strengths in the system and looked for answers inside rather than outside of VA to addressing whatever concerns they stated. Moreover, the results of PVA's membership survey revealed similar views.

It is clear from the results of both of our studies that VA should do more to sensitize staff, from physicians to residents to allied health professions, to the specific medical care needs of veterans with spinal cord dysfunction. In addition, Mr. Chairman, all veterans highly value courtesy, respect and communicativeness in their providers. There's little doubt that VA will falter under health care reform if staff do not promote themselves and follow through on its own motto of "putting veterans first."

To be most helpful, staff must be motivated by a pervasive culture that awards innovation, a management style that encourages autonomy and supports patient advocacy, and sufficient resources to empower employees to do the right thing for their patients. Without these factors, VA will have to share the blame for its employees lack of responsiveness and sensitivity.

Mr. Chairman, perceptions create their own reality and VA must be attuned to the need to meet its users' expectations, to enhance their perception of VA health care, services received. To achieve this goal, VA must become more service oriented and better equipped to actively respond to their users' needs locally.

I see that my time is out, Mr. Chairman. I'll conclude with my testimony at this time. Thank you very much.

Mr. EVANS. Thank you. The rest of your statement, Terry, will be made part of the record.

Mr. GRANDISON. Thank you, Mr. Chairman.

[The prepared statement of Mr. Grandison appears on p. 126.]

STATEMENT OF DENNIS CULLINAN

Mr. CULLINAN. Thank you very much, Mr. Chairman.

On behalf of the entire membership of the VFW, I want to thank you for involving us in today's discussion of what the future may hold for the VA health care system. As you know, the VA health care system is an overriding concern of the veterans of foreign wars

and we're pleased to take part in today's discussion. Like the other VSOs, we have little objective data to contribute to today's deliberations. Nonetheless, we have some observations that we feel warrant sharing.

I'd like to emphasize one point and it's something that we've said over and over again, through the past couple of years really, regarding VA and its health care system. It's mainly that VA should never be considered as being just another competitor. It's fine—it's all good and well to look and see what Kaiser Permanente and the other big health care providers are doing right and borrowing from them to make VA operate more efficiently for veterans. But I think all the talk of leveling the playing field and making sure that VA remains viable just as a health care provider may inadvertently have the effect of undermining our collective effort of making it the best health provider can possibly be for veterans.

Having said that, the VFW also notes that the GAO report shows a relatively high satisfaction rate among veteran users of the system and that indicates to us that VA must be doing something right as far as the provision of health care itself goes. Granted, the GAO report is based on the focus group premise. It's relatively small groups and the statistical power of that study, I'm not quite certain of it. I don't believe that we should hang the fate of the VA health care system on that one study. Nonetheless, we find it significant that it does indicate that current users seem to think that it does pretty well by them.

We also note that it predicts that a future use, that VA will remain viable. That's based on the premise that everything else remains equal. As I already said, we believe that VA should be provided with a little bit more. That because of its special mission to a special constituency, that it should be a superior HMO, which leads us to believe that it should indeed remain a highly viable system into the future. Of course, in order to achieve this end, VA needs funding and staff. As has been pointed out over and over again today, VA was not built, wasn't constructed, wasn't conceived to compete with a marketplace environment. So that means that while it is our Nation's only national health care system, its resources aren't evenly distributed. It's not readily available to all veterans.

So, these are things that are going to have to be remedied through the years. It's going to need the funding and staff to provide the kind of services that are now generally available in the private sector, while still taking care of its special obligation to those veterans with their unique needs. And the VA's resources have to be distributed in such a way that they're readily available to most veterans. Obviously, a veteran is not going to go to any health care provider if he's got to drive 100 miles. So, funding and staff are essential.

I'll conclude with one final point. Again, this is a point that has been made repeatedly today. VA has an image problem. Perceptions do create their own reality. It's quite true. Certain parts of the country, I've heard on the GAO tape today that veterans are highly satisfied with what VA is providing to them. In other parts of the country, they're totally dissatisfied. It could have to do with rudeness at the front door, or it could have to do with just mis-

conceptions and perceptions among veterans as to what is their due with respect to the provision of health care. But in any event, it's very clear that VA has to do a much better job of marketing itself. As we've said before, it could provide the very best health care in the world in the most timely fashion, but if veterans do not believe that that's what they're getting, they're going to go elsewhere.

Thank you, Mr. Chairman.

Mr. EVANS. Dennis, thank you and I want to thank the entire panel.

[The prepared statement of Mr. Cullinan appears on p. 131.]

Mr. EVANS. John, your testimony calls for a major VA cultural renaissance and as I gather from your remarks, focusing on customer satisfaction. Can you give us some of the other elements, and maybe the others will want to answer this too, of the cultural change that has to be made?

Mr. VITIKACS. I would summarize that as an issue of the process versus end product. That as someone made a statement this morning that the veterans' VA experience begins when they first walk in the door. I didn't hear in the GAO tape this morning, too many veterans talk about the quality of care they received, the end product, but I heard comments about the process. The entire process through coming in the front door to going back out that door that needs improvement. It's attitude, service, and delivery leading up to the end product.

Mr. EVANS. Mike, you raised an interesting concept about veterans having a stake in the system and doing this by community-based clinics. VA has announced that that's going to be their approach in the future, not only just community-based clinics, but continuity of care with primary care teams and so forth. But is it unfolding in the manner—maybe everybody could comment about this—is it unfolding as quickly as health care reform is going to be unfolded if it's enacted in this Congress, if the Clinton plan was adopted or something similar to it?

Mr. BRINCK. I suspect Dr. Headley has the real answer to that.

There's certainly a lot of concern about the rapidity with which VA is going to be able to react. I mean, we all know stories about how slow the government is to do things at times. If there's one thing that is critical to the VA's success—assuming that they are going to adopt that style of delivery—it's that they be able to make that transition very quickly so that they're not left behind. Not only in just the states that are out in front of the federal system, but throughout the whole nation. I mean, it doesn't make any difference whether the state is ahead of the Federal Government in reforming the way its going to do business within that particular state. The whole system in VA needs to do business in that manner.

Mr. EVANS. Would anybody else like to comment on that issue?

Would any of you dispute the GAO's assessment that perhaps as many as 47 percent of veterans currently using the VA system might leave if they were offered another provider, another alternative? Is that bad?

Mr. CULLINAN. Mr. Chairman, again, I mentioned earlier, it's hard to assess the statistical power of these special group studies that is basically small groups. But it would seem on the surface

that that's a bit high. I mean, we heard on the tape, the general satisfaction with the VA health care system. And the GAO's own report indicates a much higher level of satisfaction among veteran patient users.

Additionally, if VA is provided with the wherewithal to come into the future in a proper manner and to display itself in the right way, we think that's quite high.

Mr. GRANDISON. Mr. Chairman, I'm not prepared to rebut the statistical power of that data given by GAO. However, at PVA—we are currently working on our strategy 2000—Phase II. After its conclusion, we'll be able to provide some additional information in that study which will definitely help buttress our position.

What must be done within the VA system is, it take a proactive approach in removing these negative perceptions. We don't believe that these perceptions or the problems that are out there now are insurmountable. A lot of these things are systemic, true. But I think it was mentioned earlier that the VA has to start looking at itself now-in-house.

For example, if something is working at one VA facility, well the VA should mirroring those things they're doing there, and incorporate them throughout the system.

Mr. EVANS. Terry, PVA has conducted some surveys and focus groups. Could you submit some of those for the record, some of the most recent ones, or results of those focus groups?

Mr. GRANDISON. Oh, yes, certainly. We can amend that to the record. It will be forthcoming.

Mr. EVANS. We'll be glad to include them in the record.

John, did you have a comment?

Mr. VITIKACS. Mr. Chairman, in relation to your question about the GAO assessment of the 47 percent of current users that would leave the system. I would just like to say that there are just too many uncertain variables that are not known right now to either agree to that assessment, or even to refute that assessment.

In the future on the health care reform, its delivery network obviously has to be improved. And a lot of its problems up to this point in time have been due to constrained resources. So, we shall see how the future unfolds, but I personally would think that that is on the high end of a prediction.

Mr. EVANS. Mike.

Mr. BRINCK. I'd think it's on the high end also.

But I also think that how close they are to being correct depends largely on whether VA transitions to a community-based system. If it's a community-based system, those people who would leave VA because it's too darn far to drive—and let's face it, most of our guys are older than the average population and can't either get themselves to the facility or have to have someone drive them there. If VA becomes a community-based facility, they will, I think, retain the vast majority of the people they're seeing now. And they will gain from the population who are not able to get into the system because of the eligibility rules.

Mr. EVANS. One question before I have to go and vote. The President has directed the VA and other federal agencies to establish customer service standards. Have any of your organizations been

asked to make recommendations in regard to these standards at this point?

Mr. VITIKACS. To my knowledge, the American Legion has not, to my knowledge.

Mr. BRINCK. I don't know that we have.

Mr. EVANS. AMVETS, PVA.

Mr. GRANDISON. I concur as well. I don't know if we have been asked.

Mr. CULLINAN. I'm not sure either, Mr. Chairman.

Mr. EVANS. All right. Well, I have to vote now. I appreciate your testimony. We may submit some further questions to you. If you have any other information or if your organizations have surveys or other kind of analysis of focus groups, we'd appreciate you sharing those with us.

Mr. CULLINAN. We'll certainly do so.

Mr. EVANS. Thank you very much.

We will now recess for about a period of 20 minutes so I can go vote on the Journal. When we return, we will have the third panel comprised of Colonel Herb Rosenbleeth of the Jewish War Veterans; Linda Schwartz of the Vietnam Veterans of America; and David Gorman of Disabled American Veterans.

[Recess.]

Mr. EVANS. If everyone will please be seated, we'd like to continue with the hearing.

Members of our next witness panel also represent veterans' service organizations. Herb Rosenbleeth is the National Executive Director of the Jewish War Veterans of the USA. Vietnam Veterans of America is represented by Linda Schwartz, Chair, Vietnam Veterans of America Veterans Affairs Committee, and she is accompanied by Kelli Willard, Legislative Assistant. Dave Gorman is Deputy National Legislative Director and represents Disabled American Veterans. He is accompanied by Tom John, Deputy Adjutant, State of Maryland.

As you know, your entire statements will be made part of the record and you may summarize from them. We'll start with the Colonel.

STATEMENTS OF COL. HERB ROSENBLEETH, NATIONAL EXECUTIVE DIRECTOR, JEWISH WAR VETERANS OF THE USA; LINDA SCHWARTZ, CHAIR, VVA VETERANS AFFAIRS COMMITTEE ACCOMPANIED BY KELLI WILLARD, LEGISLATIVE ASSISTANT; AND DAVID GORMAN, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS ACCOMPANIED BY TOM JOHNS, DEPARTMENT ADJUTANT, STATE OF MARYLAND

STATEMENT OF COL. HERB ROSENBLEETH

Colonel ROSENBLEETH. Mr. Chairman, thank you for giving us the opportunity present our views at this hearing.

Mr. Chairman and members of the subcommittee, I am not at all convinced that the VA will survive under current health care proposals. These proposals seek to have a vastly under-funded VA system compete against what probably will be much better funded private health care systems.

Mr. Chairman, my telephone calls and conversations and mail indicate that many veterans who can afford to do so will not select the VA for their care. The VA over the past decade or more has been vastly under-funded in personnel, construction, equipment. And today, in many localities, it's not competitive with private health care systems. Without adequate funding starting at this time, it does not seem possible that the VA will be competitive when national health care reform is instituted.

Veterans need to be assured that they will receive the same or better quality of care as private health care systems. They need to have access to health care. It will not suffice for a veteran to call and ask for an appointment and be told five months down the road, he can have his appointment. He will need to have an appointment in an acceptable time frame, which he can get today. Citizens today with private health care, with Blue Cross, or Travelers, or Prudential can get hospital appointments on time. They get quality care. They are treated in the right way when they come to a facility. This is not the case in many VA facilities.

I looked at two avenues to improve this. One is the VA's own image, which has been presented here by the previous panel. The VA has got to improve its public relations, its image, the way its physicians and nurses and health care personnel look to the patient. They've got to have the frame of mind as private health care systems do today, that they're here to serve the patient, not that the patient is somebody here that interrupts their otherwise convenient day. So, one, the VA itself has got to improve its attitude, its image, its relationship with its patients.

And secondly, somewhere, the Congress has to be serious. The Congress has to come up with the funds to provide the personnel, the construction, the equipment, to allow the VA to be competitive with private health care systems. When I see the current budget with the VA—not only this past budget, but the past 10 years—I just do not believe that the Congress is serious about keeping the VA competitive. It almost seems like it's saying the words that's going to let the VA go down the tubes.

So, those two things have to change. Not only the approach of the Veterans Affairs Committee, but somehow, the funding has got to get through the appropriations committees. It's got to come through so that it is really delivered to the VA in a timely way, so the improvements can be made. So when national health care reform hits this country, the VA can compete. Without that, the VA will not survive in the new health care environment.

I also agree with some of my predecessors who said not only should the VA be competitive, it should be the best health care system in the country. At one time, it was. I can remember in my own mind when I first entered the service, that was the perception that I had, was that the best health care in the country was the VA. I remember that years ago. I believe it was true. I don't know whether I'm remembering it from the returning World War II veterans or exactly where, but that's the memory I have. The best research, the best physicians, the best health care was in the VA. A veteran knew, or a returning serviceman knew that his wounds, his injuries, his psychological problems, he was going to get the best available from this country.

That's not the perception today. It wasn't the perception in my closing years in the military. It's not my perception now. That has to be changed or the VA can not compete in health care environment. I also share and want to emphasize, we not only compete, the VA should be the best system. Those who risked their lives in combat should know that when they come back, at least they'll get the best health care this country can give.

Thank you, Mr. Chairman, for the opportunity to make my remarks.

Mr. EVANS. Thank you, Colonel.

[The prepared statement of Colonel Rosenbleeth appears on p. 133.]

STATEMENT OF LINDA S. SCHWARTZ

Ms. SCHWARTZ. Good morning, Mr. Chairman.

My name is Linda Schwartz and I am a disabled veteran and I do use the VA, and I have for the last 9 years. I think it has given me kind of an education to be able to come here to tell you about the perception of veterans in the VA system. In addition to the fact that I use the VA, I have also had the opportunity in the last month to visit the VA facilities in Northhampton, Albuquerque, El Paso, and of course, West Haven where I receive my care.

I want to tell you, Mr. Chairman, that some of the comments that have been made here today are right on target as far as the image. But one of the things that I would like to suggest for consideration is the fact that just as I visited four different facilities, there are four different kinds of needs in these communities. A gentleman in El Paso came up to me and suggested that perhaps the VA is a mother with many children. Each child has a different need and has a different personality, different strengths and different weaknesses.

What I have come today to suggest to you is several things. In order for the VA to be competitive—we can say that over and over again—what we're talking about now is a group of people, who because of limited eligibility, are different than those in the past. The VA also has to consider the disable veterans that they have not attracted to use the VA and to begin to look for them right now, today. VA knows who is service-connected disabled and where they are because they send them their checks. They can tell you exactly what's wrong with them. What if we had national health care reform tomorrow and those service-connected veterans had to come to the VA? What would the VA's response be? What response and capability would it have?

One of the other things that I want to point out too is that in a competitive consumer oriented health care scenario, the way in which information flows is not down. Here in the VA system, the information only flows down to the consumer. The consumer has very little opportunity in which to provide feedback. Maybe by anonymous kinds of surveys, but the fact remains that one of the things I've come to suggest is that all local VA managers have got to start now to decide what kinds of care that they need to have augment their own facilities. They need to talk to their consumers. They need to have veterans advisory committees where veterans who have to wait a long time for appointments, or have to loose

scripts at the pharmacy, or have problems, need a way in which they can communicate these problems to their own facility and get some immediate feedback.

I have been blessed many times to be able to come here and I feel a real sense of responsibility to communicate to you the needs of the people that I know. But I think that this is an opportunity that VA managers on the local level would be able to provide for some sort of relief on an immediate basis. The kinds of opportunity that we have right now. No one knows, really, what the health care reform plan is going to be? I think it's incumbent upon us to look to the VA managers to tell us what their needs are going to be. There's going to come a time if you want to be competitive, that you're not going to be able to mandate everything from the Central Office. It's going to have to be in response to the needs of the veterans where they are.

As we have heard today, there are many, many different kinds of needs and I think it has something to do with age. World War II veterans and Korean veterans, the accessibility and improved services. Someone mentioned hearing aids. In Connecticut, they have to go to New York City to get fitted for a hearing aid. That's difficult for them. But in El Paso where there are more veterans in the service care area of the VA clinic than there are in the whole State of Connecticut. In addition, 75 percent of those people are minorities and they don't even have a hospital to go to, Mr. Chairman.

Last week when I was with them, I saw how they believe in the VA. They believe and they are very proud of their service to this country. If you went down there tomorrow and asked them would they like to go to the VA hospital, they wouldn't talk about care. They wouldn't talk about time. They'd be thrilled to death. Many times VVA has come to the table and we've been somewhat cynical about saying, "well, people aren't going to use this in a competitive atmosphere." But I believe, sir, that there are veterans just waiting to be asked to come to the dance, to be able to have care. The care that they believe they deserve because of their service to this country.

Lastly, I would like to say that we have heard many things today. Most importantly, and without question, it does not matter what the VA says. What Congress does is more important, because you know and every member of this Congress and the Senate is actually the board of trustees of this largest health care system in our nation. It really does not matter what you legislate or regulate for other sectors of this government. What you are willing to fund, what you are willing to give the VA as resources to meet these challenges is going to be the determining factor on whether or not VA will be competitive and whether or not VA will survive.

Thank you.

Mr. EVANS. Thank you.

[The prepared statement of Ms. Schwartz appears on p. 139.]

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you. Good morning, Mr. Chairman. Before I begin my statement, I'd like to introduce, sitting on my right, Mr.

Tom Johns who is the Department Adjutant of the DAV, State of Maryland.

I think in trying to hold true to your letter of invitation and the purpose of today's hearing, Mr. Chairman, we did try to focus our testimony solely on what we believe to be the state of perceptions and feelings about VA health care as presented to us and told to us by veterans. Many of us in this room have sat before your subcommittee, other subcommittees, and the full committee, and we've gone over many, many of these issues and the kind of testimony we're hearing today. You've dealt with issues ranging from aging veterans to Vietnam veterans, to women veterans, to waiting times at outpatient clinics—all extremely valuable in the ongoing debate about what's going to happen to VA health care. For that and for all this activity that your subcommittee has generated about health care, we're truly grateful.

However, for today's purposes and today's hearing, I do want to concentrate on the perceptions of veterans. And in that sense, Mr. Chairman, we have submitted for the record, a survey that Mr. Johns has put together and was furnished to DAV members in the State of Maryland, sometime in the latter part of 1993. It's the summary results of that survey that I'd like to go over.

First of all, I think it's important that Mr. Johns in his efforts of conceiving this survey and completing it, didn't set out with any preconceived goal, with no bias, and not really trying to find any defined specific data, but rather to find out what veterans were thinking.

In that context, I think like most Americans, veterans—at least those who responded to the survey—were not well informed or educated about the details or the complexities of any proposal to reform the Nation's health care system. However, veterans clearly recognize and acknowledge the need to reform VA. The majority of responding veterans have used or currently use the VA in the State of Maryland for their health, and their overall opinion of the system was favorable. Also evident was the fact that 95 percent of the responding veterans had clear choices and options of where they currently receive their health care as they did have some sort of health coverage, either through Medicare and/or private health insurance.

Importantly, DAV members did not feel the system should be or could be limited to treating only service-connected disabled veterans. Rather, by a clear majority, DAV members favored not only the position of treating nonservice-connected veterans, but also felt the VA should treat dependents of service-connected disabled veterans. Not surprisingly, however, was the fact that 90 percent of DAV members felt that purely nonveterans should not be treated at VA medical facilities.

One of the more telling conclusions reached from the survey was the hypothetical situation, Mr. Chairman, of veterans being able to utilize the VA for no out-of-pocket expenses or the same out-of-pocket expenses as all other citizens under a national health care plan. Not surprising was the fact that 45 percent of the respondees would choose the VA system for their needed care. With access more attainable, 40 percent of veterans who would not normally choose VA would also opt for VA care.

Mr. Chairman, clearly our membership in the State of Maryland feels the VA is a system that needs to be maintained as an independent health care delivery system primarily for the treatment of disabled veterans and, when indicated and feasible, the treatment of dependents of service-connected veterans. Also, our membership believes the VA to be a system providing needed services to a deserving group of individuals in a quality manner. Given choices, significant numbers of DAV members choose and will continue to choose the VA as their provider of health care services.

We believe the results of the Department of Maryland's health care survey are generally indicative of the overall veterans' population. Of course, depending on many, many factors, information could be gathered from veterans representing either end of the spectrum. We believe data reasonably can be collected from veterans who would do nothing but sing the praises of the VA system. Conversely, we feel selective data could be generated that would do nothing but damn the system as one of bureaucratic entanglement and lacking any compassion or quality medical care. Certainly, we do not subscribe, Mr. Chairman, to either view, but choose to believe that veterans' perceptions lie somewhere in the middle but, as suggested by data, leaning more positively toward the VA.

Mr. Chairman, you talked about the fact of the GAO study and 47 percent of veterans may leave the system according to the data they generated. I think it is important to note—and not many people tend to think about this or talk about it— but veterans today do have choices. Clearly, they have choices. The VA in their Medical Cost Care Recovery Program collects somewhere in the neighborhood of $600 million from veterans who have private insurance, but choose to use the VA for their care. With the simple addition of a better information and computer system, they estimate that overnight, they could collect another $100 million on top of that, simply with that improved data and collecting ability.

So, there are choices out there that veterans have, but yet they choose to use the system. As Linda, I'm a combat disabled veteran and I choose to use the VA for my health care. I think too—I guess we could go on and on about some of these different issues that have been talked about and what veterans really think and feel. I was talking to Ms. Marjorie Quandt, who's sitting in the back of the room, who has had a long, long career with the VA, and retired some time ago after the Mission Commission concluded its work. She served as their Executive Secretary.

I think Marge would relate that certainly, this kind of discussion never used to go when we were talking about VA health care some years ago. Some years ago, you had the same kind of veterans using the system. You had new hospitals being built. You had new programs coming on board. You had a large influx of veterans coming to the system from Vietnam. You had the Congress mandating the VA provide additional services. But back then, also provided was the resources to go along with those demands. There were human resources available and there were financial resources available. With those, the VA was able to treat veterans in a manner that they still do today in large part, in a quality, compassionate, timely manner.

The demand on the system was not as great as it is today. The resources have, in essence, dried up in many instances. The VA is therefore forced to do certain things. As a result, I think you hear some of the stories and get some of the feelings that you're hearing.

I see my time is up, Mr. Chairman. If I may, I'd like to ask Mr. Johns to perhaps give his views about what he sees and hears about the VA in his capacity as a day-to-day disabled veterans advocate, sitting up in Baltimore.

[The prepared statement of Mr. Gorman appears on p. 146.]

STATEMENT OF TOM JOHNS

Mr. JOHNS. Thank you, Mr. Chairman.

I would only like to add that the survey may appear to have given a very small response, but mass mailers look at a one percent response as average. We intentionally hid this survey inside of our standard newspaper, looking to get responses from veterans who truly had an interest in what President Clinton was proposing as national health care, to find out what they knew and how they felt. We wanted to do this because we wanted to find out how much they wanted us to provide to them on an informational basis as we got information about the plan.

The surveys that came in had numerous comments written on the margins and on the reverse side, et cetera. We talked to veterans outside of the surveys and the great preponderance of those, as Dave brought up, are in favor of expanding the VA system to encompass dependents, to give that wider variety of care. They are not in favor of other nonveterans being in the system. And they do, for the most part, feel that the system is good. Not that it is error-free. It is flaunt with errors, as with almost any system that we use today.

They're in favor of retaining the VA system as a specialized health care and a general health care system. Thank you, sir.

Mr. EVANS. All right. Thank you.

Listening to the focus group comments today, are they typical of what you hear in your organizations in terms of the variety of different attitudes that were expressed?

Mr. GORMAN. I think so, Mr. Chairman. You know, we receive phone calls and we get letters also. I think you tend to hear from people who are usually dissatisfied with the service as opposed to those who are pleased with it. Although we do get, actually, an increasing number of letters from veterans who are pleased with the VA and want us to know that because I think they hear so much bad publicity.

Mr. Gutierrez was talking about the quality of care issue earlier. With any system that takes care of 24 million veterans on an outpatient basis every year, and over a million discharges from hospitals, you're bound to have problems. The VA is really the only system, if you will, that delivers health care in the quantity they do. I do think you hear those diversional views and I think they're all valid.

Mr. EVANS. Colonel?

Colonel ROSENBLEETH. Yes, I would say the same thing. I do think they have presented a wide range of views and as Dave said, I think they think they're valid, yes. I've heard some of the same,

similar comments that were on that tape. It was an excellent presentation.

Mr. EVANS. Very well.

Ms. SCHWARTZ. I would agree with my colleagues here, but I was thinking that it would probably be more valuable if those people would have had the opportunity to sit down with their VA administrator on their local level and actually tell him what was on their mind.

That's my point about the advisory committees, which would allow—a dialog. Here there's a lot of latitude for criticism, but what would the person who runs the place say or be able to do to actually take care of these problems on a local level? And what would those veterans be able to suggest to the Administrators as remedies? I think the tapes was a very good way of putting this into focus and it's too bad that you don't have that chance every time to hear comments. But those comments are representative, certainly.

Mr. EVANS. Colonel, you indicated that we've slipped away from being the best institution, at least the perception of being the best institution or superior institution. Can you pinpoint when that happened and why it happened? Was it because of the decline of resources, human and financial resources?

Colonel ROSENBLEETH. I can't pinpoint when, Mr. Chairman. I think it's over a period of time. I think, yes, it's a decline of resources.

As I say, take research, for example. I can remember clearly the view that the VA was where the research happened. I guess maybe it even goes back to—I was 6, 7 years old when they were coming home from World War II. I was 8 years old in 1945. I remember one relative in particular, very, very badly wounded, shot in the face, the back, the legs. I remember how he went to the VA. He had many procedures done. They really put him back together again. I remember him saying how dedicated the physicians were, the research that was done there.

Today, the research money has slipped. Every year that we testify, all the veterans' organizations speak about the need for VA to maintain the level of research. It attracts physicians who want to do that kind of thing. That perception is not there today, that the front-line research is done at the VA, in the way I remember it. And again, it's subjective in my own mind and I'm going back to when I was 8 years old. But somehow, it has declined over a decade or two decades and it's not what it was. It will take money to bring it back to where it was before. And again, that's a personal perception.

Mr. EVANS. You are suggesting it's not only that maybe 47 percent of current users will not use VA, the entire system may fall apart?

Colonel ROSENBLEETH. Oh, I'm suggesting that could happen, yes, absolutely. It would happen not all at one time. As we've heard today, in some places, the VA hospitals are excellent; in other places, they don't come up to that standard. But I think that unless the funding is there, I am suggesting the whole VA system would be in danger. Yes, I am.

Mr. EVANS. Let me ask you the same question I asked the previous panel of veterans' service organization representatives. Have your organizations been asked to recommend customer service standards to the VA at this point, to the best of your knowledge?

Colonel ROSENBLEETH. I don't know that I've heard, but I would second that one. Our organization would. I haven't heard those particular words, but sure, that's how——

Mr. EVANS. But you haven't been asked yet?

Colonel ROSENBLEETH. I haven't been asked that question no, that I know of, but some good points.

Mr. EVANS. Linda?

Ms. SCHWARTZ. No, sir, we haven't.

Mr. GORMAN. Not as of yet.

Mr. EVANS. All right. VA is overhauling its patient representative program. Have the service organizations been asked to recommend improvements in the VA's patient representative program? And what improvements would the members of this panel recommend?

Mr. GORMAN. I'm not so sure, Mr. Chairman, that we've been asked to participate in that. I think what we would recommend, number one, is a dedicated person or individual be allowed to do that as the sole function of their employment.

It was interesting, during the task force meetings that were here in town during January, one of the directors employed five patient representatives on his staff. And they were not to sit in an office behind a desk waiting for veterans to come in, but rather, they went out and circulated through the hospital and through the clinics. When they saw something that was amiss, whether it be a veteran waiting in the same place at the same clinic for more than a prescribed period of time, they went and found out why. And that's a proactive function that needs to be done, not simply wait and react to what goes on.

Mr. EVANS. Where was this done?

Mr. GORMAN. I knew you were going to ask me that. It was in Georgia. I don't know——

Ms. SCHWARTZ. Augusta, I believe.

Mr. GORMAN. Augusta, Tom Ayers.

Mr. EVANS. Thank you.

Colonel ROSENBLEETH. Mr. Chairman, could I make one comment on this line?

VA Secretary Jesse Brown has started to meet with the Executive Directors on an every-other-month basis. This is something that had never been done before. He gets everybody together and he hears these kind of comments from the Executive Directors or their representatives. There was a comment made in the last meeting, one of the VA Assistant Secretaries, about something that couldn't be done. Rick Shultz made a comment, asking for a point. The Assistant Secretary said, "it can't be done" and Jesse ordered that "it will be done."

So, I want to plug Jesse Brown for doing that. He does get us together every other month and he listens to the viewpoints, and he takes action.

Mr. EVANS. All right, thank you.

Ms. SCHWARTZ. I would like to just say that we have not been asked, on a formalized basis, to have any input into patient representative service, but certainly, on a local level we have.

Vietnam Veterans of America has because I have been kind of pushing the idea of developing these advisory committees on local level to help veterans. That's one of the places where I know I have had the experience of being able to do that at the West Haven VA, by pinpointing problems and bringing it to the attention of the administration there. It goes to the patient service representative and they're on the lookout for that. So, that's really a local way in which I hope to show you the importance of Advisory Committees.

And the last thing I would like to say is, it would be wrong for me to miss responding to that question that you asked just before. What happened to the VA system and when did it go awry?

You know, almost a third of today's veterans came from the Vietnam era. And at that time, I don't think the government or the people in the communities and even the physicians were really very excited about working in the VA system because it seemed that there was a terrible influx of patients and there wasn't enough resources. You will probably recall that from those conditions, Vietnam Veterans of America was actually born.

Mr. EVANS. Thank you.

Mr. GORMAN. Mr. Chairman, can I make a point too——

Mr. EVANS. Certainly.

Mr. GORMAN (continuing). On the patient representative question?

I would stick by my answer, however, Dr. Barbour has also convened a task force dealing with the patient satisfaction survey being led by Dr. Wilson, who is going to be testifying, I think, about that. And I did sit on that panel and represented the views of the DAV. I think they're going to turn out a good product and she probably has some good data already.

I would make one more point if I could. Mr. Rosenbleeth talked about research and how it had slipped and I would agree with that. But I would also state that had it not been for VA, and if it were not for VA, the kind of research that folks like myself who tend to rely on and look forward to as far as rehabilitative research, as far as spinal cord injury, wheel chairs, prosthetics, rehabilitative aids—if it weren't for the VA, then I would guess that that kind of research in this country would be a fraction of what it is now to improve the day-to-day life and quality of life of the severely disabled. Because no one does that except VA.

Mr. EVANS. Yes, good point, Dave.

Thank you very much. We appreciate your testimony.

Our next witness is Dr. Elwood Headley, the Acting Deputy Under Secretary for Health, Department of Veterans Affairs.

Dr. Headley, for the record, please introduce, once you get situated, those who are accompanying you this morning. And obviously, you know that your entire prepared statement will be made part of the record. Once your folks get situated, you can introduce them and proceed.

STATEMENT OF DR. ELWOOD J. HEADLEY, ACTING DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DR. GALEN L. BARBOUR, ASSOCIATE CHIEF MEDICAL DIRECTOR FOR QUALITY MANAGEMENT, VETERANS HEALTH ADMINISTRATION; DR. NANCY M. VALENTINE, ASSISTANT CHIEF MEDICAL DIRECTOR FOR NURSING PROGRAMS, VETERANS HEALTH ADMINISTRATION; DR. NANCY J. WILSON, DIRECTOR, NATIONAL VETERANS HEALTH ADMINISTRATION PATIENT FEEDBACK PROGRAM

Dr. HEADLEY. Thank you, Mr. Chairman.

With me this morning are Dr. Nancy Valentine, who is the Assistant Chief Medical Director for Nursing Programs; Dr. Galen Barbour, who is the Associate Chief Medical Director for Quality Management; and Dr. Nancy Wilson, who is the Director of the National Veterans Health Administration Patient Feedback Program.

Mr. Chairman, thank you for this opportunity to discuss Veterans' Perceptions of VA Health Care. Planning is now underway to make the profound changes in the VA health care system necessary for us to succeed in a health care reform environment. We fully appreciate the importance of perception and correcting deficiencies in service that lead to negative perceptions. We are interested in the anecdotal reports of the GAO focus groups and feel that these comments are important to us as we go about our future planning.

One recently published article entitled "Patient Satisfaction in VA Medical Centers and Private Sector Hospitals: A Comparison," compares veterans' perceptions of inpatient care at VA medical centers with that of patients in the private sector. On the 12 parameters measured, VA patients were as satisfied as those in the private sector with their care, including that from direct care providers, physicians, nurses, and social workers.

I just cite this article by way of pointing out that we must have more balanced and validated information as we go about this process if we are called to make real-life decisions based upon this information. Understanding veterans' perceptions of current VA health care and what they desire from a future VA health care delivery system will be absolutely critical to VA's future success.

Our goal is to provide veterans with affordable health care that is easily accessible, of the highest quality, and delivered with courtesy and respect. It is not enough that VA simply maintain the customers, patients, we now serve, we must appeal to veterans who either do not currently look to VA as their provider, or because of complex eligibility rules, can not gain access to VA health care. We will take our lead from what veterans tell us they want from a health care delivery system and redesign our health care services around these stated needs.

First and foremost, VA health care reform will make health care readily accessible to veterans and their families. We will correct scheduling and assignment problems in our outpatient clinics to end the long waits that have troubled our health care delivery in the past. We realize if we are to survive, we must do these things. Our proposals also include plans for providing more community-based care through sharing agreements and for making health care accessible to veterans living in remote areas.

Mr. Chairman, we believe that the President's proposed Health Security Act, H.R.3600, is consistent with our goal of providing health care that is responsive to the unique needs of the veteran population. H.R.3600 recognizes the special health needs of veterans and the importance of a strong VA health system. The Health Security Act contains provisions for veterans and their families to have choice in selecting a health plan. Moreover, it authorizes VA to establish networks of community providers to treat this expanded clientele. As a health plan, VA would be a choice open to all 26.8 million veterans and their 33 million dependents. VA would guarantee a comprehensive benefits package to all veterans and their families who enroll. We believe that VA has an opportunity and the vision to become the health plan of choice to many veterans and their families.

When we began planning for VA's health care reform last year, we did so mindful of the 1987 GAO study which indicated that given a choice, nearly half of the veterans who now use VA would go to a non-VA provider. In addition, we had the information from the CBO report, Congressional Budget Office Report, issued in 1992 which said that about 25 percent of veterans now using VA as their health care provider would go elsewhere. Though neither report takes into account improvements in VA health care that H.R.3600 would make possible, we heeded the findings as we set out devising a health care reform plan that would ensure VA's long-term survival and success in a reformed environment.

Under health care reform, we will need to know considerably more about veterans' perceptions of VA health care and how comfortable they would be enrolling in a VA health plan. A VA national study conducted in January of this year supplies up-to-date information on veterans' perceptions of VA health care and their propensity for enrolling along with their families, in a VA health plan.

In this study, approximately 1,500 veterans from across the country participated in structured telephone interviews. The three categories of veterans surveyed included current users, previous users, and non-users. A significant finding from the survey indicated that 66 percent of current users, 47 percent of former users and 27 percent of non-users surveyed would be favorably disposed toward enrolling in a VA health plan.

As a result of quality of care problems at a few VA medical centers, a negative perception persists about VA health care that affects the entire system. VA recognizes that issues such as waiting times, access, and less-than-courteous staff are recurring problems. And that until they are corrected, we will continue to suffer from them, perceptually as well as operationally.

In our continuing effort to remain in touch with what is important to our customers, we have changed the assessment tool used to measure customer satisfaction. In its place, we plan to implement a customer feedback loop that will measure seven identified standards of quality.

Mr. Chairman, my time is up. I will conclude my comments at this point and we will be happy to answer any questions.

[The prepared statement of Dr. Headley appears on p. 150.]

Mr. EVANS. Thank you, Doctor. We appreciate your testimony.

You were here when GAO played the tape, were you not?

Dr. HEADLEY. Yes, sir.

Mr. EVANS. What was your own personal reaction to it, working in the VA and hearing the comments, both positive and negative?

Dr. HEADLEY. I think that these are the kinds of comments that we hear around the system. I think that these represent opportunities for improvement in scheduling, in length of time to appointments, in waiting times when people arrive at the hospital. I think that these are the very sorts of issues that we are aware of and we are working to address as we go about redesigning VA services under health care reform.

Mr. EVANS. But you know, when I think patients meet a doctor or a visiting Congressman, let's say, that they're more guarded in their comments, maybe not wanting to look ungrateful or worried about whether the services might be cut back to them or to an institution that they would complain. And that's why I find these kind of focus group comments to be very valuable.

I know the VA has done some patient focus groups in the past.

Dr. HEADLEY. Yes.

Mr. EVANS. Do you have those taped and then reviewed by staff at local hospitals?

Dr. HEADLEY. I'd like to refer this question to Dr. Wilson who has been very active in this area and is developing a focus group.

Mr. EVANS. Dr. Wilson.

Dr. WILSON. I personally conducted focus groups around the country last year of veterans and their family members. I did audiotape those. I had permission to use those to develop the instrument that we're currently going to implement for patient feedback. I did not have permission from those veterans to disseminate that information back to their local system.

What we would like to do in the future is to—and I've already begun speaking to groups around the country—have local facilities conduct their own focus groups. There are members within each of the VA facilities that with minimal training, would be quite capable of doing professional jobs at conducting focus groups. I think that that's a valuable resource for facilities to become patient focused in their entire organizational structure.

So, I agree that the comments that were on the GAO tape were things that I've heard as well around the country, but I think it's more critical with the diversity that we have, for individual facilities to learn to start talking to their patients and incorporating that information into their organization.

Mr. EVANS. I think it would be very valuable for any staff person to hear some of these comments. Those that may be in the paperwork and the administrative side, as well as the professional nurses, doctors, and so forth. And so, I hope that that can be done in the future.

The Legion had brought up the issue of a survey that is starting to be formulated right now, and specifically requesting that the sampling include women veterans in that sampling collection. Is that going to happen in terms of a——

Dr. HEADLEY. If I may, I'll refer that to Dr. Wilson again.

Dr. WILSON. The pilot study that we did around the country with our survey instrument sampled based on the population within the

VA. So, it was 97 percent male, 80 percent white. It followed the sampling scheme that is of our population. We do know the numbers of women who responded and we'll be able to analyze their data separately. And the numbers that we're talking about are 7,600 patients, so we should have reasonable amounts of information about women veterans.

When we disseminate this—when we decide to roll this survey instrument out to all VAs in the country, we can change our sampling strategy based on what seems to be of most need for the individual facilities.

Mr. EVANS. In terms of VA conducted focus groups, how have patients' concerns then been disseminated within the VA and how has the VA responded to the patient concerns raised in these focus groups, do you know?

Dr. WILSON. What I did around the country was involve the patient representative with me to conduct the focus groups. So, in some ways, the patient representative functioned as an expert consultant in the language of focus groups. Any concerns that came about that were related to issues for that particular facility, the patient rep then was responsible for problem solving with that patient.

But I must add that the intent of our focus groups at that time were to ask patients how they defined a high quality health care experience. It was only incidental that we learned about problems with their pharmacy medications, et cetera.

Mr. EVANS. Well, I'm concerned about collecting information that's valuable, but then not accomplishing anything once you obtained that information. Can you give us some specific accomplishments that have occurred as a result of the surveys?

Dr. HEADLEY. Yes, if I could just add on to this a bit. This data and process that Dr. Wilson is engaging in I think has not gone full cycle yet in terms of feeding information in and seeing what results come back from feeding this information back to facilities. This is planned for the very near future. In fact, however, Dr. Wilson participated in our health care reform efforts and shared this information, and it has become part of the information base that we are using to attempt to improve patient service.

Mr. EVANS. Before I yield to minority counsel, I have some questions concerning the issues which have been raised and the concerns that have been expressed by patients. I'll submit these questions to you and your answers will be made part of the record.

Minority Counsel?

Ms. DONOHUE. Thank you, Mr. Chairman.

Dr. Headley, on page 8 of your statement, you say that "under health care reform, the VA will be conducting business in much the way it is done in the private sector."

Can this be done without departing materially from the present budgetary process?

Dr. HEADLEY. I think that that statement was used a bit euphemistically. By doing business much like in the private sector, what we were attempting to convey there is that we were going to have to pay attention to patients' concerns. That we were going to have to find out how patients wanted care delivered, and how we

could best go about meeting those needs and becoming customer service oriented.

Ms. DONOHUE. On page 4 of your testimony, you say that "a recently completed VA national survey indicated that the reason stated most often by veterans for choosing a VA health plan over competing plans is good service, quality care, and happy with VA care."

Did the survey indicate that convenience of location and accessibility were important factors in determining choice of health care?

Dr. HEADLEY. That was not one of the things that came out of that survey. That is, of course, true. That is one of the factors that we have taken very much to heart in thinking about reforms and new ways that we need to do business under health care reform, and the fact that we will have to have accessible services in order to attract users of the system.

Ms. DONOHUE. How many potential users of DVA care live within 50 miles of a health care facility?

Dr. HEADLEY. Obviously, I can get that information and give it to you. I don't have that information at my fingertips this morning.

I think a more important question though to ask would be as we establish networks and we establish outpatient care clinics, primary care clinics, how accessible would those be to potential users? We will submit an answer to your question for the record.

Ms. DONOHUE. I would appreciate it. Thank you.

You state that findings of a VA national survey indicate "that 67 percent of current users would be favorably disposed toward enrolling in a VA health plan."

In conducting the survey, how did you structure your sampling in terms of a veteran's distance from VA care facilities?

Dr. HEADLEY. I don't believe that was a consideration in that particular survey.

Ms. DONOHUE. Thank you, Mr. Chairman.

Mr. EVANS. You're welcome. Thank you.

Doctor, can the VA improve service to veterans and reduce full-time equivalent employment from 13,000 to 27,000 people over the next 5 to 7 years?

Dr. HEADLEY. That's a very difficult question to address with any degree of certainty. Under health care reform, the likelihood that we would need to adjust our approach to care delivery in any given market is very great. How much we would need to contract out, how much we would need to buy from other providers is a really unanswered question and one that we're just beginning to explore. This would have profound impact on the number of FTEE that we would have to have on board. Also, the potential for combining services with our affiliated institutions is another factor that makes it very difficult for me to answer that question at this point in time.

Mr. EVANS. In talking about national health care reform, the Secretary is very proud of the fact that the VA is very cost efficient. If that is true, how do we obtain substantial savings if we're going to contract out additional services?

Dr. HEADLEY. It depends on the services. There are some services that it is quite cost effective to contract out. It is much more expensive to buy your own primary care providers and scatter them

around the community than it is to contract with already existing providers in a network situation and pay them on a per capita basis for patients enrolled in your plan, for which they may deliver primary care to your specifications. You may pay as little as $10.00 a month-per-person on a capitated basis to a provider who would cost you well over $100,000.00 if you had to go out and have them on your roles.

There are also other services which can be more cost effective in contracting or purchasing, such as food services and perhaps housekeeping services. It varies with the community. It varies with the contract. But there can be cost savings in contracting out.

Mr. EVANS. Vet Centers represent one of the VHA's most successful programs. They provide vital services to a large number of veterans and some dependents every year. How does the Vet Center program fit into the VA's proposed reform? Does the Department intend to alter the way the Vet Centers are run or change the organizational structure of the readjustment counseling centers?

Dr. HEADLEY. Yes. I can't speak to whether or not there are any plans in the organization to alter the way Vet Centers are structured or organized. I'm not aware that there are any. Certainly, under health care reform, this is one of our core programs that we would consider very important and one of the programs that we would want to see continue.

Mr. EVANS. You heard Mike Brinck talk about having Vet Centers or outpatient clinics give a stake to veterans, and I think that's particularly true of this program. I'm a strong proponent and would be very much opposed to any substantial changes in the independence or the organizational structure of this program because of its tremendous success. So, if you do become aware of any plans to change it, I'd like to know.

Are you planning to colocate the regional offices with the Vet Centers?

Dr. HEADLEY. I'm not aware of that. I could ask if that has been suggested, and provide that in writing.

Mr. EVANS. I understand that Dr. Blank's contract is not going to be renewed. If that's true, has VHA begun searching for a new director of the Readjustment Counseling Service?

Dr. HEADLEY. I believe they have. Dr. Blank has elected to go to a midwestern health care VA facility. I'm not exactly sure which one. It won't be for several months, I believe, and I think that certainly, his replacement will be actively sought.

Mr. EVANS. The President has directed the VA to establish customer service standards. Has the VA done that at this point?

Dr. HEADLEY. We are in the process—we have two different parts of the organization working on this at the present time. We are just in the process in VHA of gearing up to do this. We have not begun doing this yet and we take very strongly the suggestion that it would be good to include veterans' service organizations as we develop our customer standards.

We have involved veterans' service organizations throughout our health care planning process and we certainly intend to include veterans' service organizations and very, very strong veterans' input into our future plans and into our local facilities.

Mr. EVANS. I have a number of questions I want to submit in writing. Because of this pending vote I will yield to Minority Counsel in case she has any other questions.

Ms. DONOHUE. No more questions.

Mr. EVANS. The one thing I'd like to leave you with is one very troubling concern, I think, that the GAO focus groups indicated, that there is tremendous confusion in the veterans' community over what national health care reform means to veterans. Whether it's going to diminish their services, whether it's going to cause changes in the way that an individual obtains services from the VA. We certainly have problems with the public image of the VA right now. As this unfolds, we have deep concerns within the veterans' community over just what's happening and what will be unfolding in the near future. So, that's one impression I wanted to leave with you that I got from those tapes.

Dr. HEADLEY. Thank you. I think it's going to be very important for us to communicate directly with veterans communities about changes and about possibilities as they occur.

Mr. EVANS. All right. We will submit some questions for the record and ask that you respond to them in a timely manner. They will be made part of the record of this hearing.

With that, we will now conclude this hearing. Thank you for your participation.

[Whereupon, at 11:18 a.m., the subcommittee was adjourned.]

APPENDIX

Prepared statement of Chairman Evans

Today's hearing is on veterans' perceptions of VA health care. In the past, this Subcommittee has examined a wide range of veterans health care issues. These have included:

- The long waits too many veterans face for outpatient care;
- The health problems of Persian Gulf veterans and their dependents;
- The concerns of African-American veterans;
- VA care for older veterans;
- VA's ability to meet its missions in time of war;
- Inequities in access to VA health care;
- VA health care for women veterans; and
- Long waits for specialty care appointments.

These hearings have shared a common element -- How well is VA providing services to veterans? In large part, that is also the subject of today's hearing.

I don't believe any veteran should be forced to wait months for a VA specialty clinic appointment;

I don't believe any veteran should be expected to wait all day for routine VA outpatient care; and

I don't believe any veteran who has driven hundreds of miles to VA for a scheduled appointment should be told, "Sorry, you'll have to come back tomorrow."

What I do believe is that veterans have earned, should expect and then receive first class quality and first class service from VA -- service that is second to none -- service that sets the standard. Today, VA service is less than first-rate too often.

In recent testimony, Dr. Headley told this Committee that VA must change and consistently provide veterans and their dependents with first class service. The chair cannot agree more strongly.

With or without health reform, VA service to veterans must be improved, but the advent of reform places even more importance on VA providing better service to veterans now.

Today, VA and other health care providers are poised at the beginning of a new era in health care.

Under the President's health care reform plan, VA will vie even more directly with others to serve veterans. And VA is expected to expand the range of care it offers to meet the needs of veterans' dependents.

Health care reform clearly presents significant challenges to VA. Various studies have reported that from one-fourth up to nearly one-half of veterans may select a non-VA health care provider if given the option. VA will be challenged to both retain current patients and attract new veterans to the VA system.

Several years ago former President Reagan talked about people voting with their feet. In a competitive health care environment, veterans will vote with their feet for health care.

To his credit, VA Secretary Brown has recognized that health care reform is an important opportunity for VA to serve even more veterans. He has directed VA to get ready to meet this challenge.

Today, some veterans who want to receive VA health care can't. Other veterans who can use VA don't.

While many veterans are very satisfied with the quality of the care they receive from VA, others are frustrated and turned off by their VA experiences.

VA is an important national resource and asset. Not every health care provider can serve the needs of veterans.

I want VA to succeed. I want VA to not only survive, but to thrive. I believe it can. But VA must change to meet the very

real challenges of a competitive environment. It can meet these challenges and continue its historic mission of providing health care to veterans by providing better service.

To succeed, VA must change -- today. More than in the past, VA must better serve veterans, understand what veterans want and respond quickly. This hearing will help identify the changes veterans want in VA health care. It will better prepare VA to meet the challenges of health reform and a more openly competitive environment. This hearing will provide a real-world look at what changes VA needs to make.

On many occasions this Subcommittee has directed VA's attention to opportunities for improving services to veterans. In some cases, VA has made needed improvements. But in others, little change has been realized.

This Subcommittee has also shown there are many highly talented and dedicated people in VA. At some facilities these individuals have succeeded in providing better services to veterans. But these improvements are largely the result of individual personal initiative by one or a few employees at that single facility. These improvements and successes are not widely known. More rarely are they duplicated or repeated. This must change.

While VA may be the biggest health care system, it becomes very small when it comes to sharing information and communicating good ideas among all medical centers and clinics.

There are literally a hundred ways to better serve veterans today. Perhaps this Subcommittee should conduct a hearing to focus attention on innovative local programs providing better service to veterans. Maybe then VA would systematically and routinely identify and publicize these service-improving opportunities.

Several service organizations survey and regularly report to local management on needed improvements in service to veterans. In many cases these recommended improvements aren't costly, but they do require a change in attitudes or procedures. Too often

it seems these suggestions for better service take years to be acted on.

The Blue Ribbon Panel on Claims Processing produced useful recommendations. But the challenge of better claims adjudication has not ended. This effort too should be regular and ongoing. Efforts to improve services to veterans shouldn't be given real attention only once in a blue moon.

Our veterans organizations should be regularly and formally recommending health care service improvements to VA. And VA's responses to these recommendations should be regularly monitored by this Committee and the service organizations.

There have been enough five year plans, task force reports, TQM seminars and working groups. We just don't want plans. We want results and better service for veterans.

Change is not always easy, even when it's necessary. VA is a large ship and large ships can be hard and slow to turn. But when they do not turn quickly enough, they can run aground.

Decisions made by Congress and the Executive Branch will certainly have considerable influence, but ultimately veterans' decisions will determine the future course of VA health care.

We look forward to hearing from today's witnesses. We want to know what veterans think of VA health care and receive testimony on the related issues previously identified by the Subcommittee as part of today's hearing.

EXECUTIVE ORDERS
No. 12862

Executive Order 12862 of September 11, 1993

Setting Customer Service Standards

58 F.R. 48257

Putting people first means ensuring that the Federal Government provides the highest quality service possible to the American people. Public officials must embark upon a revolution within the Federal Government to change the way it does business. This will require continual reform of the executive branch's management practices and operations to provide service to the public that matches or exceeds the best service available in the private sector.

NOW, THEREFORE, to establish and implement customer service standards to guide the operations of the executive branch, and by the authority vested in me as President by the Constitution and the laws of the United States, it is hereby ordered:

Section 1. *Customer Service Standards.* In order to carry out the principles of the National Performance Review, the Federal Government must be customer-driven. The standard of quality for services provided to the public shall be: Customer service equal to the best in business. For the purposes of this order, "customer" shall mean an individual or entity who is directly served by a department or agency. "Best in business" shall mean the highest quality of service delivered to customers by private organizations providing a comparable or analogous service.

All executive departments and agencies (hereinafter referred to collectively as "agency" or "agencies") that provide significant services directly to the public shall provide those services in a manner that seeks to meet the customer service standard established herein and shall take the following actions:

(a) identify the customers who are, or should be, served by the agency;

(b) survey customers to determine the kind and quality of services they want and their level of satisfaction with existing services;

(c) post service standards and measure results against them;

(d) benchmark customer service performance against the best in business;

(e) survey front-line employees on barriers to, and ideas for, matching the best in business;

(f) provide customers with choices in both the sources of service and the means of delivery;

(g) make information, services, and complaint systems easily accessible; and

(h) provide means to address customer complaints.

Sec. 2. *Report on Customer Service Surveys.* By March 8, 1994, each agency subject to this order shall report on its customer surveys to the President. As information about customer satisfaction becomes available, each agency shall use that information in judging the performance of agency management and in making resource allocations.

Sec. 3. *Customer Service Plans.* By September 8, 1994, each agency subject to this order shall publish a customer service plan that can be readily understood by its customers. The plan shall include customer service standards and describe future plans for customer surveys. It also shall identify the private and public sector standards that the agency used to benchmark its performance against the best in business. In connection with the plan, each agency is encouraged to provide training resources for programs needed by employees who directly serve customers and by managers making use of customer survey information to promote the principles and objectives contained herein.

Sec. 4. *Independent Agencies.* Independent agencies are requested to adhere to this order.

Sec. 5. *Judicial Review.* This order is for the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable by a party against the United States, its agencies or instrumentalities, its officers or employees, or any other person.

William J. Clinton

THE WHITE HOUSE,
September 11, 1993.

Office of Public Affairs
News Service

Washington, D.C. 20420
(202) 535-8300

Department of Veterans Affairs

News Release

FOR IMMEDIATE RELEASE

VA AND UNIONS SIGN NATIONAL PARTNERSHIP AGREEMENT

Washington, April 12 — The Department of Veterans Affairs (VA) and five employee unions have entered into an historic agreement to establish the VA National Partnership Council (VA NPC), a joint labor-management partnership to improve VA services.

Represented on the council are the American Federation of Government Employees (AFGE), the National Federation of Federal Employees (NFFE), the National Association of Government Employees (NAGE), the Service Employees International Union (SEIU), and the American Nurses Association (ANA).

At a signing ceremony today, VA Secretary Jesse Brown said, "It is with great pleasure that I enter into this partnership. By working together we can improve services to America's veterans, improve the work environment, and improve the functioning of one of the government's largest departments. This is just another step toward achieving our goal of 'putting veterans first.'"

The VA NPC is being established in response to Executive Order 12871, which calls for a new form of labor-management relations throughout the executive branch to design and implement comprehensive changes necessary to reform government.

-more-

The VA National Partnership Council is comprised of two members from each of the five unions and a total of 10 VA management members. The council will be cochaired by a representative from labor and management, who will rotate the responsibility for conducting quarterly meetings. The aim of the VA NPC is to involve employees and their union representatives as full partners with management representatives to identify problems and craft solutions to better serve the nation's veterans.

The VA NPC will strive to assure implementation of local partnerships, develop methods of voluntarily resolving disputes without the use of a third party, identify training needed to accomplish partnership objectives, address department policies and procedures which affect employees and veteran services and improve day-to-day VA operations.

As one of the largest federal agencies, VA has approximately 170,500 employees represented by unions. Some 98 percent of these employees are represented by the VA partner unions.

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News Service

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(202) 535-8300

Department of Veterans Affairs

VA Fact Sheet

VA NATIONAL PARTNERSHIP COUNCIL

April 1994

Executive Order 12871 directed federal agencies to establish a new form of labor-management relations throughout the executive branch to achieve the National Performance Review's reform objective -- to create a government that works better and costs less, cuts waste and reduces bureaucracy. Only by changing the nature of federal labor-management relations so that managers, employees, and employees' elected union representatives serve as partners will it be possible to design and implement comprehensive changes necessary to reform government.

Executive Order 12871 established the National Partnership Council comprised of ten members appointed by the President. The members of the council are: the Director of the Office of Personnel Management; Deputy Secretary of Labor; Deputy Director for Management, Office of Management and Budget; Chair, Federal Labor Relations Authority; Federal Mediation and Conciliation Director; President, American Federation of Government Employees, AFL-CIO; President, National Federation of Federal Employees; President, National Treasury Employees Union; Secretary-Treasurer of the Public Employees Department, AFL-CIO; and a deputy secretary or other officer with department- or agency-wide authority from two executive departments or agencies, not otherwise represented on the council. Members have a 2-year term on the council which may be extended by the president.

VA NATIONAL PARTNERSHIP AGREEMENT

Following the directive outlined in Executive Order 12871, on April 12, 1994, VA entered into an agreement with five of its major unions to establish the VA National Partnership Council (VA NPC), a joint labor-management partnership to improve VA services. Serving on the VA NPC are two members each from the American Federation of Government Employees (AFGE), the National Federation of Federal Employees (NFFE), the National Association of Government Employees (NAGE), the Service Employees International Union (SEIU), and the American Nurses Association (ANA). Approximately 170,500 VA employees are represented by unions. The partner unions represent about 98 percent of these employees. Also on the VA NPC are ten VA managers representing Human Resources Management, General Counsel, National Cemetery System, Veterans Health Administration and Veterans Benefits Administration.

-more-

VA NPC cont'd.

The VA NPC will:

* Assure local implementation of partnerships and provide guidance to facilities on ways to foster local partnerships including specific examples of actions that have been useful such as union membership of facility committees, joint training programs, and work groups to address issues of mutual interest.

* Provide guidance to partners at all levels in developing plans to implement alternative dispute resolution systems to reduce the number of formal disputes and the need for third parties in dispute resolution.

* Develop a procedure to evaluate progress and improvements in organizational performance resulting from the labor-management partnership.

* Identify training needed to accomplish partnership objectives to include examples of successful partnership experiences in VA and other federal agencies; interest-based bargaining techniques; alternative dispute resolution approaches; and communication and cooperation skills.

* Foster a harmonious atmosphere of communication through the sharing of all information that will affect the relationship of this partnership. To this end, a national newsletter or publication will be established and distributed to local facilities to highlight partnership accomplishments and progress.

Founding Partners

Founding partners and signers of the VA National Partnership Agreement include, for the unions: Jennifer L. Bailey, R.N., Representative, American Nurses Association; Walter Glockler, 1st Executive Vice-President, AFGE National VA Council; Rhonda Glover, President, SEIU, Local 551; Louis Jasmine, Secretary/Treasurer, NFFE VA Council and President, NFFE Local 1904; Steve Kreisberg, American Nurses Association, Center for Labor Relations; Alma L. Lee, President, AFGE National VA Council; Lorraine Payton, President, NFFE VA Council; Susanne J. Pooler, National Vice-President, NAGE; Lena M. Russell, President, NAGE, R 14-8; Steve Schwartz, Director, Professional Council, SEIU AFL-CIO, CLC.

VA management partners include: Vincent Barile, Director, Office of Operation Support, National Cemetery System; Robert Blair, Director, VA Medical Center, Tuscaloosa, Ala.; John Coghlan, Director, Personnel Assistance Staff, Veterans Benefits Administration; Ronald E. Cowles, Deputy Assistant Secretary for Human Resources Management; Jonathan H. Gardner, Director, Field Support, Southern Region, Veterans Health Administration; Audley Hendricks, Assistant General Counsel; Jack McReynolds, Director, VA Regional Office, Denver, Colo.; R. Stedman Sloan, Jr., Director, VA Regional Office, Columbia, S.C.; Fred Watson, Director, Field Program Service, National Cemetery System; and David Whatley, Director, VA Medical Center, Hampton, Va.

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VHA HEALTH CARE REFORM
CUSTOMER SATISFACTION SURVEY

Prepared for

VHA HEALTH CARE REFORM PROJECT OFFICE

March, 1994

HOLLANDER COHEN & MCBRIDE

EXECUTIVE SUMMARY

INTRODUCTION

In February, 1994, VA's Health Care Reform project office commissioned a market research firm to survey current and former VA patients, as well as veterans that have never used VA. The survey questionnaire was approved by OMB (control number 2900-0548) under blanket authority granted to VA for implementation of Customer Satisfaction Surveys (Executive Order 12862).

The purpose of the survey was to analyze the preliminary demand, or market potential for a veteran health plan. It identifies preliminary marketing data that will help guide strategic thinking and provide direction for a more comprehensive baseline study to be conducted later in 1994.

METHODOLOGY

Fifteen hundred (1,500) veterans were telephone-interviewed between February 19 and February 28, 1994. The targeted interviews were split between current users of VA medical services (used VA health system within past year), former users (have not used the health system in the past year), and a random group of non-users (never used VA health system) controlled for location around current and former users.

The listings for current and former users were generated randomly from 143 of the 171 medical centers. A random sample from that master list of twelve thousand names was used as the base. Random-digit dialing was used to contact non-users and it was found that about one in seven households had a veteran. Respondents from 49 of the 50 states are included in the survey. The distribution of inpatient/outpatient is as follows:

	CURRENT USERS	FORMER USERS
Inpatient	22%	24%
Outpatient	33	50
Used both	45	26

Ninety-five percent (95%) of the respondents are male and the median age of the sample is 60.2 years.

PRINCIPAL FINDINGS

- Rating VA health care services on a 1 - 5 scale (5 being excellent), current users rate it highest – 72% gave it a 4 or 5 rating – compared with 61% for former users and 35% for non-users. Those over 45 years of age rate the health services higher than those younger. While income level does not affect current users' ratings, low income former and non-users give VA higher ratings.

- When asked to rate VA on ten specific customer service attributes, current users give the highest ratings on all ten, former users next highest and non-users lowest on each one. It is a positive sign that those who know the service first hand are much more favorable. It represents a communication/image lag that non-users are skeptical of the VA's performance.

- Cleanliness of the facilities; courtesy and respect shown by the staff; safety of locations and the nursing staff are the highest rated attributes. The lowest are: waiting time for a scheduled appointment and convenience of the locations.

- In line with the attitudes of the three groups, current users are more likely to opt for VA health insurance over a private health plan (assuming no change in cost) than either former or non-users of VA health care.

	CURRENT USERS	FORMER USERS	NON-USERS
Select VA	66%	47%	27%
Select other	26	44	63
Undecided	8	9	10

Inpatients, those using VA over 5 years, and those over age 45 are subgroups that have above-average interest in VA insurance. Among non-users, those under 45 are more amenable to VA insurance.

- There is probably some favorable VA bias since respondents are aware of the survey's sponsorship and there is generally a gap between what respondents say and what they'll do when it comes to purchasing a new product or service. Additional factors that will influence the actual outcome include:
  - the extent and intensity competitors market themselves
  - the extent and competence in which VA markets itself
  - the pricing of VA plans versus competing plans
  - the actual delivery network

- Quality of care is a leading reason for choosing VA insurance. Reasons for choosing a private plan include: quality of care, poor VA location, lack of trust in VA and satisfaction with present provider.

- There is price sensitivity in selecting a health plan. Among veterans who selected a private plan, a substantial proportion in each of the three groups would change their choice to the VA plan if VA's plan offered a cost advantage.

	CURRENT USERS	FORMER USERS	NON-USERS
Would still choose private plan	39%	50%	48%
Would switch to VA	51	43	40
Don't know	10	7	12

To attract most of these switches, the VA cost advantage would have to be 10%.

- VA's commitment to veterans' needs is a positive influence for all three groups but especially for users.

	CURRENT USERS	FORMER USERS	NON-USERS
Positive influence	63%	50%	30%
Negative influence	8	10	13
No influence	29	40	57

- There is a strong positive reaction to a family option plan which would permit veterans to be treated by the VA or by community providers and dependents to be treated by community providers.

	CURRENT USERS	FORMER USERS	NON-USERS
Positive influence	60%	53%	52%
Negative influence	7	8	8
No influence	33	39	40

- A demographic profile of the three groups follows:

	CURRENT USERS	FORMER USERS	NON-USERS
Household size	2.4	2.5	2.5
Median age	61.8	61.3	57.2
Have health care coverage (other than VA)	56%	74%	83%
Have Medicare	61%	40%	22%
Employed full-time	18%	27%	50%
Retired	67%	62%	41%
Median income	$17,904	$23,941	$34,535

- Current users travel 79 minutes on average to reach a VA facility and do so about 6.5 times a year.

- Former users last visited a VA facility an average of seven years ago (median three years ago).

- Current users have been using VA health services an average of 13 years while former users had done so for 9. Inpatients have longer periods of use than outpatients.

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SURVEY INSTRUMENT

DISTRIBUTION OF SAMPLE AND INTERVIEWS BY FACILITY

PURPOSE AND METHOD

The purpose of this study is to obtain an initial assessment of veteran satisfaction with VA medical services and to obtain a measure of veterans' loyalty to the system, if and when, alternative choices become available. An objective was to differentiate opinions by current users, former users, and veterans who had never used the system.

Telephone interviews were used in order to meet time constraints and to obtain a more representative response than a mail survey might provide. There were 1,500 telephone interviews completed between February 19 and February 28, 1994. The interviews were split between 500 current users of VA medical services, 500 former users, and a random group of non-users controlled for location to match current and former users.

The survey instrument was designed in consultation with VA representatives. The initial survey draft was tested and VA representatives participated in the debriefing of the test interviewers. The instrument was revised for clarity and understanding.

The lists of potential respondents supplied by Veterans Affairs were generated by taking extracts from the 85-gigabyte Integrated Patient Data Base (IPDB) Oracle Relational Database Management System located at the Hines Information Systems Center. Initial screening of the database using PL/SQL and SQL*Plus identified those veterans falling under the following four categories:

- Veterans seen during FY93 and the first four months of FY94 at a VA facility as an Outpatient only.
- Veterans seen during FY93 and the first four months of FY94 at a VA facility as an Inpatient, but could be an outpatient as well.
- Veterans who were seen in a VA facility as an Outpatient only prior to February, 1991 and has no further inpatient or outpatient activity reported as of February, 1994.

- Veterans who were seen in a VA facility as an Inpatient prior to February, 1991 and has had no further Inpatient activity reported as of February, 1994.

Once these veterans were identified, a random selection routine was developed to select veterans for an interview. The total number of veterans fitting the criteria for each category was divided by 6,000. The resulting quotient was used as n, and every nth record was selected for inclusion in the extraction routines which were then sent to the appropriate facility to gather names and phone numbers.

Lists from Veterans Affairs had 14,696 potential respondents with roughly 3,700 respondents in each of four segments— current inpatients, current outpatients, former inpatients, and former outpatients. As the quota was 250 interviews in each segment, a random sample was taken from the VA disk of 1,500 in each segment or 6,000 potential respondents. This insured random selection across the files provided.

Current users were defined as veterans who had used VA medical services over the past year. The quota for this group was 500 equally divided between in-patients and out-patients.
A random sample with names and phone numbers of current in-patients and current out-patients was supplied by Veterans Affairs. Quota was based on the list source although some interviews were moved to other categories after the interview.

Former users were defined as veterans who had used VA medical services more than 12 months ago. The quota was 500 equally divided between in-patients and out-patients.
A random sample with names and phone numbers of former in-patients and former out-patients was supplied by Veterans Affairs. Quota was based on the list source although some interviews were moved to other categories after the interview.

Non-users were defined as veterans who had never used VA medical services.

Veterans and their use of VA medical services were identified by screening household members nationwide. Phone contact was made through a random digit dial technique. The technique also controlled for location by having random calls made into exchanges where other veterans had used VA medical services. This method is superior to a completely random sample listing because it ensures that veterans in these areas were not so isolated that VA medical services could not be accessed. Lack of access for non-use of VA medical services was not considered actionable for purposes of the present study.

Veterans contacted randomly who were current or former users were interviewed and used to complete quotas of users. The random method used was to add an incremental number to the last digit of a random sample of current and former users. This procedure was preferable to a listed sample because veterans with unlisted numbers were included.

Quotas were also imposed by time zone. The objective was to match the percentage of completed interviews with the sample provided from Veterans Affairs. Following is the summary distribution of sample and interviews by time zone. Random interviews resulted in interviews with residents of every state, except Nevada.

	TOTAL SAMPLE	INTERVIEWED
EASTERN STANDARD	49.9%	50.4%
CENTRAL	34.5	34.1
MOUNTAIN	3.4	3.6
PACIFIC	12.1	11.8

The furnished sample included station numbers which represent VA medical facilities throughout the country. A table of the sample and interviews by station number has been provided in the Appendix and indicates how the interviewed sample is representative of the one supplied by the VA.

Preliminary tabulations were completed and reviewed on March 3rd. Subgroups were recommended for analysis in the final report and are included in final tabulations.

Using a sample of 500 random interviews, results are accurate at a 95% confidence interval within ± 5%. In comparing two samples with 500 random interviews in each, differences are significant when they exceed 8%.

HEALTH CARE REFORM CUSTOMER SATISFACTION SURVEY
SAMPLE DISPOSITION

	Current Inpatient	Current Outpatient	Former Inpatient	Former Outpatient	Total List Sample	Random Digit Sample
Disconnected/Not In Service	146	60	247	311	764	3,968
No Answer/Answer Mach.	188	162	137	311	798	5,979
Non Quota/No Medical Service (List)	9	14	20	69	112	
Non Quota/No Veteran (Random)						4,858
Terminate User of Medical Services (Random)						91
Wrong Number	184	54	94	377	709	
Non-Residential Number						1,297
Not Available/Callback	116	95	52	82	345	622
Refused	45	44	44	121	254	655
Deaf/Language/Incapacitated	43	10	10	4	67	60
Deceased	65	4	54	103	226	
Nursing Home/Hospital #	221	3	115	20	359	
Interviewed	198	196	198	194	788	725*
Total	1,215	639	971	1,592	4,417	18,253

* 503 Non Users
109 Current Users
103 Former Users

HOLLANDER COHEN & MCBRIDE

VETERAN MEDICAL SERVICE USAGE

In random contact of residents nationwide, 14% of households had a veteran. Veterans made more use of VA Medical Services than other services available to them.

USE OF VA SERVICES
AMONG THOSE RANDOMLY CONTACTED

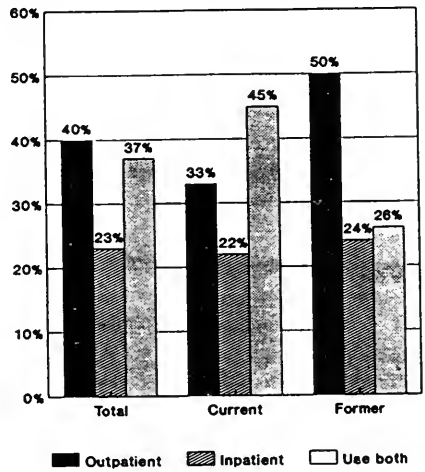
	TOTAL VETERANS
Medical Care Benefits	38%
Education Benefits	35
Home Loan Benefits	28
Rehabilitation/Compensation Benefits	8
Sample Base	(724)*

*Medical Service users included 48 respondents who had to be prompted to qualify as a user and 91 respondents screened for medical service usage, but not interviewed.

The quotas of contacts for users of VA Medical Services based on VA lists were 500 current users and 500 former users evenly split among inpatients and outpatients. Segments were divided based upon veteran responses and reflected a greater representation of current users and inpatients.

Question 3: (If have received medical care from VA), whether you have been an inpatient or outpatient.

VA MEDICAL SERVICES
INPATIENT/OUTPATIENT COMPOSITION



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Current users, by definition, had used VA Medical Services over the last year. Former users last used VA Medical Services an average of seven years ago and a median of three years ago.

Question 4: How long ago did you last use any VA health care services?

	TOTAL FORMER USERS	INPATIENT	OUTPATIENT ONLY
1 - 2 years ago	34%	37%	31%
3 - 4 years ago	30	23	36
5 - 9 years ago	15	17	14
10 years or longer	21	23	19
Total	100%	100%	100%
Sample Base	(420)	(212)	(208)
Mean (Years)	7	8	6

Current users of VA Medical Services travel an average of 79 minutes to reach their VA medical facility.

Question 5: How long does it usually take to get to their facility?

	TOTAL CURRENT USERS	INPATIENT	OUTPATIENT ONLY
Less than 30 minutes	19%	18%	23%
30 - 44 minutes	16	15	16
45 - 59	10	8	14
1 hour	18	18	18
1 - 2 hours	12	12	11
2 hours	11	12	9
Over 2 hours	14	16	9
Total	100%	100%	100%
Sample Base	(584)	(390)	(194)
Mean (Minutes)	79	87	64

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Current users used VA Medical Services an average of 6.5 times over the last year. As might be expected, inpatients used medical facilities more often than outpatients.

Question 6: In the past year, how frequently have you used VA for health services or testing?

	TOTAL CURRENT USERS	INPATIENT	OUTPATIENT ONLY
Used once	26%	28%	21%
Twice	17	16	20
3 - 4 times	22	20	28
5 - 9 times	16	14	19
10 - 19 times	13	15	8
20 or more	6	7	4
Total	100%	100%	100%
Sample Base	(580)	(388)	(192)
Mean	6.5	7.2	5.1

Current users have used VA Medical Services longer than former users and inpatients have used VA Medical Services longer than outpatients.

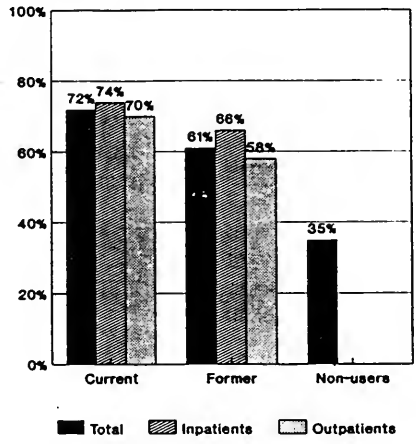
Question 7: For about how long (have you been using/did you use) VA for health services?

	CURRENT USERS			FORMER USERS		
	TOTAL	INPATIENT	OUTPATIENT	TOTAL	INPATIENT	OUTPATIENT
Less than 1 month	2%	2%	2%	15%	14%	17%
1 month - 1 year	8	8	9	8	6	11
1 - 2 years	12	10	17	9	6	13
2 - 5 years	15	11	23	22	22	22
5 - 10	15	18	9	11	12	11
10 - 20	22	23	17	17	20	14
20 + years	26	28	23	18	20	12
Total	101%	100%	100%	100%	100%	100%
BASE	(577)	(387)	(190)	(412)	(208)	(204)
Mean	13	14	11	9	10	7

PERCEPTIONS OF VA HEALTH CARE SERVICES

Not surprisingly, current users are more satisfied with VA health care services than are former and non-users. Also, inpatients in both the current and former user groups are slightly more satisfied than are outpatients.

PERCENT SATISFIED* WITH VA HEALTH CARE SERVICES



* 4 and 5 ratings on a 1 - 5 scale

RATINGS ON VA MEDICAL SERVICES ATTRIBUTES

Respondents rating several specific aspects of VA health care services. While current users gave the highest satisfaction ratings for each attribute (former users were next highest and non-users lowest on each of the attributes), all user groups ranked the attributes in nearly the same order. Appearance and cleanliness of facilities and courtesy and respect shown by the staff received the highest rating while respondents were clearly least satisfied with waiting time for a scheduled appointment and location convenience.

RATINGS ON VA MEDICAL SERVICES
(% Satisfied)*

	CURRENT USERS	FORMER USERS	NON-USERS
Appearance/Cleanliness of facilities	88%	80%	56%
Courtesy & respect shown by staff	84	79	60
Safety of locations	84	72	52
Nursing staff	83	71	47
Comfort of facilities	80	69	46
Filling prescriptions	79	69	44
Quality of physicians	76	68	49
Handling records	75	70	40
Convenience of locations	64	57	46
Wait time for scheduled appointment	52	45	25

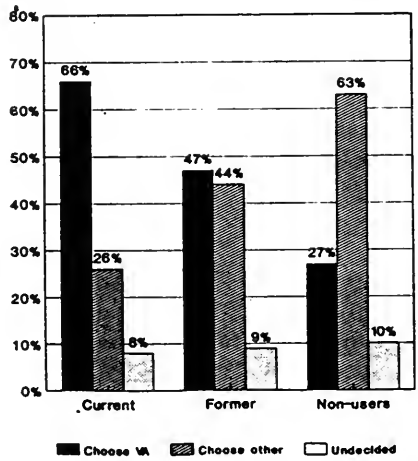
*4 and 5 ratings on a 1 - 5 scale.

CHOICE OF HEALTH CARE PROVIDER

Assuming no difference in cost, most current users of VA health care services (66%) would choose the VA if they had a choice between VA sponsored health care coverage and coverage from some other private plan. Former users are split almost evenly while non-users are much more likely to choose a private health plan.

Question 10: *The government is considering changes that would affect health care options. If there were no change in the cost to you, and you were offered a choice between either health care coverage sponsored by the VA which would include a network of community providers, or one from some other private health plan, for example, Blue Cross, Kaiser-Permanente, or some other HMO, which one would you be most likely to choose – VA or some other private plan?*

CHOICE BETWEEN VA AND OTHER HEALTH CARE PROVIDER



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Quality of care is a major reason volunteered for choosing the VA or for selecting an alternative. Interestingly, current and former users of the VA service, those with first hand experience, seem particularly happy with the care they receive.

Main reasons for choosing a private plan (other than good service) are better locations and doubts about quality of the VA staff. Negative experiences with VA are also a deterrent for choosing the VA plan.

Mentioned most by respondents who were undecided on their choice of plan was not having enough information to make a choice.

Question 11: If chose VA sponsored health care coverage, reasons for that choice.

REASON FOR CHOOSING VA

	CURRENT USERS	FORMER USERS	NON-USERS
Good service/Quality care/Happy with them	67%	72%	39%
Facilities especially for Vets	11	11	26
No experience with other plans	11	9	4
Well qualified doctors/staff	9	11	8
Specialty care for Vets	5	2	1
Close to where I live	4	8	7
Don't like other plans	4	3	15
More benefits/coverage/feel secure	4	2	6
Other	2	1	2
Don't know	1	1	4
Total	118%	120%	112%
BASE	(388)	(196)	(135)

Question 11: If chose private health care plan/HMO, reasons for that choice.

REASONS FOR CHOOSING PRIVATE PLAN

	CURRENT USERS	FORMER USERS	NON-USERS
Better quality of service/care/coverage	32%	26%	20%
Location of VA not convenient	29	26	13
Better quality staff/expertise	19	8	6
Don't trust/like VA/bad experiences	18	25	26
Like current provider/private doctor	12	15	32
More variety/choice of doctors/facilities	10	12	1
No experience with VA/not eligible	2	0	10
Other	2	1	2
Don't know	0	2	1
Total	124%	115%	121%
BASE	(154)	(184)	(318)

Both the VA's commitment to the specialized needs of veterans and the option of a family coverage plan have a positive influence on whether respondents would choose the VA as a health care provider. It is striking that non-users are nearly as likely as current and former users to be positively influenced by the option of family coverage, as shown below. Respondents focused more on the advantage of family coverage than on the potentially negative aspects of the veteran being treated in a VA facility and the family member being treated in a different facility.

Question 12: *Does VA's commitment to the specialized health needs of veterans have a positive, negative, or no influence in your consideration of them as your health care provider?*

	CURRENT USERS	FORMER USERS	NON-USERS
Commitment to health needs of vets has positive influence	63%	50%	30%
Has negative influence	8	10	13
Has no influence/neutral	29	40	57
Total	100%	100%	100%
BASE	(584)	(417)	(498)

Question 13: *What if VA also offered the option of a family coverage plan, in which veterans could be treated in either VA or community facilities, and dependents would be treated by community providers. Would this option have a positive, negative, or no influence upon your decision about whether to choose VA or not?*

	CURRENT USERS	FORMER USERS	NON-USERS
Option of family coverage plan has positive influence	60%	53%	52%
Has negative influence	7	8	8
No influence/neutral	33	39	40
Total	100%	100%	100%
BASE	(582)	(418)	(500)

Cost is a major factor, particularly among current users of VA medical services, in choosing a health care provider. When those who opted for a private plan were asked if they would still make that choice if it cost more than the VA plan, one half of current users indicated they would decline to do so. Of those who still would choose a private health plan even if it cost more, most would be willing to pay up to 10% more for the plan; 20% of current users would pay up to 25%.

Question 14: *What if it cost you more to choose another health care plan than it would cost to use the VA system, would you still choose that provider?*

	CURRENT USERS	FORMER USERS	NON-USERS
Yes, would still choose provider other than VA	39%	50%	48%
No, would not	51	43	40
Don't know	10	7	12
Total	100%	100%	100%
BASE	(200)	(224)	(368)

Question 15: *In percentage terms, how much more would you be willing to pay for some other plan over VA's-- would you say?*

	CURRENT USERS	FORMER USERS	NON-USERS
Up to 10% more	58%	61%	47%
Up to 25% more	20	22	32
Up to 33% more	0	3	3
Up to 50% more	12	3	9
Up to 75% more	0	2	2
Up to 100% more	5	7	4
More than twice as much	5	2	3
Total	100%	100%	100%
BASE	(79)	(113)	(189)

DEMOGRAPHICS

Most respondents live in a two-person household.

Question 18: Household Size

	CURRENT USERS	FORMER USERS	NON-USERS
One person	18%	17%	16%
Two people	52	48	47
Three	15	15	17
Four	9	12	12
Five or more	7	7	8
Total	100%	100%	100%
BASE	(586)	(418)	(500)
Mean	2.4	2.50	2.54

Roughly three quarters have no children in the household under age 18.

Question 19: Number in household under age 18.

	CURRENT USERS	FORMER USERS	NON-USERS
None	78%	78%	72%
One person	11	11	14
Two or more people	11	11	14
Total	100%	100%	100%
BASE	(578)	(417)	(499)

18

Non-users were somewhat younger than current and former users.

Question 20: Age of Respondent

	CURRENT USERS	FORMER USERS	NON-USERS
Under 25	2%	0%	2%
25 - 34	5	4	7
35 - 44	11	12	14
45 - 54	16	21	23
55 - 64	24	20	21
65 - 74	33	32	27
75 and older	10	10	6
Total	100%	100%	100%
BASE	(586)	(414)	(497)
Median	61.8	61.3	57.2

More former and non-users than current users have other coverage in addition to VA benefits.

Question 21: Whether have any (other) health care coverage of any type, including Medicare, in addition to VA benefits.

	CURRENT USERS	FORMER USERS	NON-USERS
Yes, have other coverage	56%	74%	83%
No, do not	44	26	17
Total	100%	100%	100%
BASE	(586)	(417)	(502)

Of those who have additional health coverage, current users are more likely to have Medicare, while former and non-users are more likely to have coverage from another private plan.

Question 22: *If have any health care coverage in addition to VA, who provider is.*

	CURRENT USERS	FORMER USERS	NON-USERS
Medicare	61	40	22
Another private insurance plan (HMO, self-insured co., etc.)	37%	50%	65%
Blue Cross/Blue Shield	18	22	27
Medicaid plan	8	4	3
Total	124%	116%	117%
BASE	(327)	(309)	(417)

Current and former users of VA medical services appear to be less educated than non-users.

Question 23: *Last grade of school completed.*

	CURRENT USERS	FORMER USERS	NON-USERS
Less than high school	27%	23%	11%
High school graduate	38	40	42
Some college/technical school	25	21	26
Four year college degree	6	11	15
Postgraduate work	4	5	6
Total	100%	100%	100%
BASE	(584)	(415)	(501)

More non-users than current and former users are employed. Two-thirds of current users are retired.

Question 24: Employment Status

	CURRENT USERS	FORMER USERS	NON-USERS
Employed full-time	18%	27%	50%
Employed part-time	5	6	4
Retired due to age/disability	67	62	41
Full-time student	1	0	0
Not employed	9	5	5
Total	100%	100%	100%
BASE	(585)	(415)	(501)

Current users have the lowest median annual household income of the three user groups.

Question 25: Household Income

	CURRENT USERS	FORMER USERS	NON-USERS
Under $20,000	56%	43%	22%
$20,000 - $39,999	33	38	38
$40,000 - $59,999	7	13	25
$60,000 - $79,999	3	4	8
$80,000 - $100,000	1	1	3
Over $100,000	0	1	4
Total	100%	100%	100%
BASE	(521)	(360)	(448)
Median	$17,904	$23,941	$34,535

Almost all respondents were male.

Question 26: *Gender*

	CURRENT USERS	FORMER USERS	NON-USERS
Male	95%	96%	96%
Female	5	4	4
Total	100%	100%	100%
BASE	(588)	(420)	(503)

SURVEY INSTRUMENT

Hollander Cohen & McBride 22 West Rd. Ste. 301 Towson, Md. 21204 410-337-2121 #6123

VA MED BENEFITS 6 -1 E -2 C -3 M -4P

Good evening/afternoon. I'm..... of Hollander, Cohen & McBride. We're doing a survey for the Department of Veterans Affairs. (May I speak with [LIST NAME].) [REPEAT INTRODUCTION IF NECESSARY]. This survey is about healthcare, and my listing indicates you have used VA medical facilities for health services or tests. Is that correct? (IF AFFIRMED, CONTINUE; OTHERWISE, TERMINATE.]

IF RANDOM DIAL:
(Is there anyone in your household who is a veteran of the military? May I speak with him/her?) [REPEAT INTRODUCTION IF NECESSARY] This survey is about the healthcare of veterans.

All replies are completely confidential and will be used for research purposes only. THIS SURVEY HAS BEEN APPROVED BY O.M.B. UNDER O.M.B. APPROVAL #2900-0458 AND WILL TAKE APPROXIMATELY 10 MINUTES TO COMPLETE.

START LISTED RESPONDENTS AT Q. 3

TIME BEGUN_____

1. Which of these benefits available from the VA have you used?

		YES	NO
a. Medical care benefits?	10	-1	-2
b. Education benefits?	11	-1	-2
c. Home Loan benefit?	12	-1	-2
d. Rehabilitation or compensation benefits?	13	-1	-2

2. [IF NO TO MEDICAL BENEFITS]
Have you ever received any medical services, either treatment or testing, from a VA hospital or medical center?
20
-1 YES -2 NO—>[SKIP TO. Q. 8]

3. Has the medical care you've received from the VA been as an inpatient, that is, admitted to the hospital for an overnight stay, or only as an outpatient, i.e. come to a clinic for tests or care, or both?
30
-1 INPATIENT -2 OUTPATIENT -3 BOTH

4. How long ago did you last use any VA healthcare services?
40
-01 WITHIN THE PAST YEAR (CURRENT) ____ ___ YEARS AGO (SKIP TO Q. 7)

5. About how long does it usually take you to get to their facility? ____ ____ [ ]MIN [ ]HRS
50 [ ] HOME CARE ONLY

6. In the past year, how frequently have you used the VA for health services or testing?

— ____ ___ TIMES
60

7. For about how long (have you been using / did you use) the VA for health services?____ ___
70

8. Overall, using a scale of one through five, with one meaning very poor, and five meaning excellent, how would you rate VA healthcare services? (either from your own experience or your impressions.)
80
VERY POOR -1 -2 -3 -4 -5 EXCELLENT

9. Now I'd like you to use the same rating system to rate some specific aspects of VA healthcare services. These ratings can be based on either your satisfaction through actual experience or just your impressions. First the [CHECKED ITEM], using the scale of one through five, with one meaning very poor, up through five meaning excellent, how would you rate [REPEAT 1st ITEM]?

ROTATE		VERY POOR				EXCELLENT	DK
a. overall quality of nursing staff	90	-1	-2	-3	-4	-5	[ ]
b. overall quality of physicians	91	-1	-2	-3	-4	-5	[ ]
c. length of waiting time to be seen when you have a scheduled appt.	92	-1	-2	-3	-4	-5	[ ]
d. appearance & cleanliness of medical facilities	93	-1	-2	-3	-4	-5	[ ]
e. handling of your records	94	-1	-2	-3	-4	-5	[ ]
f. filling prescriptions	95	-1	-2	-3	-4	-5	[ ]
g. courtesy & respect shown by staff	96	-1	-2	-3	-4	-5	[ ]
h. convenience of the medical facilities locations	97	-1	-2	-3	-4	-5	[ ]
i. safety of locations	98	-1	-2	-3	-4	-5	[ ]
j. how comfortable the facilities are	99	-1	-2	-3	-4	-5	[ ]

10. The government is considering changes that would affect healthcare options. If there were no change in the cost to you, and you were offered a <u>choice</u> between either healthcare coverage sponsored by the VA which would include a network of community providers, <u>or</u> one from some other private health plan, for example, Blue Cross, Kaiser-Permanente, or some other HMO, which one would you be most likely to choose--the VA or some other private health plan?
100
-1 VA -2 OTHER -3 DK/UNDECIDED

11. Why is that? _____
_____
111 112 113

12. Does the VA's commitment to the specialized health needs of veterans have a positive, negative, or no influence in your consideration of them as your health care provider?
120
-1 POSITIVE -2 NEGATIVE -3 NONE/NEUTRAL

13. What if the VA also offered the <u>option</u> of a family coverage plan, in which veterans could be treated in either VA or community facilities, and dependents would be treated by community providers. Would this option have a positive, negative, or no influence upon your decision about whether to choose the VA or not?
130
-1 POSITIVE -2 NEGATIVE -3 NO INFLUENCE

**IF CHOOSE -1 VA IN QUES. 10 ABOVE, SKIP TO INTRO TO DEMOS

14. What if it cost you more to choose another health care plan than it would cost to use the VA system, would you still choose that provider?
140
-1 YES/OTHER -2 NO/VA [SKIP TO INTRO TO DEMOS] -3 DK

15. In percentage terms, how much more would you be willing to pay for some other plan over the VA's--would you say....
150
-1 up to 10% more,
-2 up to 25% more,
-3 up to 33% more,
-4 up to 50% more,
-5 up to 75% more,
-6 up to 100% more, that is, twice as much, or
-7 even more than that?

Now, I have a few questions for statistical purposes only.

16. In which state do you live? _____
160

17. Do you consider your neighborhood to be city, suburban, or more country rural?
170 -1 CITY -2 SUBURBAN -3 RURAL

18. Including yourself, how many live in the household? _____[IF "1", SKIP TO Q. 20]
180

19. How many, if any, are under the age of 18? _____
190

20. In what year were you born? ____ ____ ____ ____
200

21. Do you currently have any (other) healthcare coverage of any type, including Medicare (in addition to your VA benefits)?
210
-1 YES -2 NO [SKIP TO Q. 23]

22. Is this through: [CIRCLE ALL THAT APPLY]
220
-1 a Blue Cross/Blue Shield plan,
-2 another private insurance plan, (INCL. HMO, SELF-INSD CO. ETC)
-3 a Medicaid plan, or
-4 Medicare?

23. What is the last grade of school you completed?
230
-1 LESS THAN HIGH SCHOOL
-2 HIGH SCHOOL GRADUATE
-3 SOME (1-3 YRS) COLLEGE OR TECHNICAL SCHOOL
-4 4 YR. COLLEGE GRADUATE
-5 POSTGRADUATE WORK/STUDIES

24. Are you currently....
240

-1 employed full time,

-2 employed part time,

-3 retired due to age or disability,

-4 a full-time student, or

-5 not employed at the present time?

25. Is your household's total income from all sources over or under $40,000?
250

[ ] OVER

Is it between:

-3 40 to 60,000

-4 60 to 80,

-5 80 to 100, or

-6 over that?

[ ] UNDER

Is it between:

-2 20 to 40,000, or

-1 under $20,000?

[ ] REFUSED

26. RESPONDENT IS: -1 MALE -2 FEMALE
260

Thank you very much for your time, information, and opinions. Good night.

TIME ENDED_____

INTV. LENGTH_____

PHONE NO:_____ NAME IF LISTED_____

27. CODE FACILITY NO. IF AVAILABLE _____
270

28. SAMPLE IS FROM: -1 CURRENT INPATIENT LIST -2 FORMER INPATIENT LIST
280 -3 CURRENT OUTPATIENT LIST -4 FORMER OUTPATIENT LIST
-5 RANDOM DIGIT DIALING LIST

INTVR._____

DATE_____

VERIFIED BY_____

DISTRIBUTION OF SAMPLE & INTERVIEWS BY FACILITY

Distribution of Sample and Interviews By Facility

Station Number	Facility Name	Sample Frequency	Completed Interviews
402	Togus	20	0
405	White River Junction	58	7
436	Ft. Harrison	1	0
437	Fargo	88	11
438	Sioux Falls	62	5
442	Cheyenne	30	2
452	Wichita	54	7
459	Honolulu	25	2
460	Wilmington	233	18
463		36	0
500	Albany	100	6
501	Albuquerque	44	4
502	Alexandria	193	20
503	Altoona	267	20
504	Amarilla	86	3
505	Tacoma	86	2
506	Ann Arbor	102	6
508	Atlanta	312	16
509	Augusta	316	15
512	Baltimore	50	4
513	Batavia	6	0
514	Bath	167	10
515	Battle Creek	97	3
516	Bay Pines	144	12
517	Beckley	6	0
518	Bedford	38	0
519	Big Spring	44	1
520	Biloxi	106	3
521	Birmingham	125	4
522	Bonham	42	2
523	Boston	192	16
525	Brockton	66	8
526	Bronx	85	8
527	Brooklyn	303	14
528	Buffalo	23	0
529	Butler	46	1
531	Boise	57	3
532	Canandalgua	56	2
533	Castle Point	320	18
534	Charleston	25	1
535	Chicago (Lakeside)	64	9
537	Chicago (Westside)	43	2
538	Chillicothe	80	7

Station Number	Facility Name	Sample Frequency	Completed Interviews
539	Cincinnati	37	1
540	Clarksburg	6	0
541	Cleveland	324	19
542	Coatsville	67	1
543	Columbia, MO	111	10
544	Columbia, SC	38	3
546	Miami	320	14
549	Dallas	317	14
550	Dansville	98	2
552	Dayton	122	10
553	Allen Park	55	3
554	Denver	55	2
555	Des Moines	55	2
556	North Chicago	61	3
557	Dublin	72	3
558	Durham	138	10
562	Erie	32	4
564	Fayetteville, AR	49	3
565	Fayetteville, NC	41	1
566	Ft. Howard	3	0
567	Ft. Lyon	13	0
568	Ft. Meade	24	1
569	Ft. Wayne	57	3
570	Fresno	50	4
573	Gainesville	159	5
574	Grand Island	24	1
575	Grand Junction	56	1
578	Hines	305	11
579	Hot Spring	18	4
580	Houston	151	12
581	Huntington	60	2
583	Indianapolis	115	10
584	Iowa City	97	9
585	Iron Mountain	53	3
586	Jackson	34	1
589	Kansas City	74	6
590	Hampton	24	1
591	Kerrville	69	3
592	Knoxville	44	2
594	Lake City	109	2
595	Labanon	87	6
596	Lexington	93	11
597	Lincoln	35	4
598	Little Rock	48	6
599	Livermore	55	1
600	Long Beach	341	17

Station Number	Facility Name	Sample Frequency	Completed Interviews
603	Louisville	87	5
604	Lyons	58	3
605	Loma Linda	144	3
607	Madison	110	11
608	Manchester	58	5
609	Marion, IL	75	6
610	Marion, IN	67	4
611	Marlin	17	1
612	Matinez	147	6
613	Martinsburg	107	5
614	Memphis	98	7
617	Miles City	29	1
618	Minneapolis	331	17
619	Montgomery	12	0
620	Montrose	56	1
621	Mountain Home	77	2
622	Murfreesboro	108	0
623	Muskogee	65	1
626	Nashville	65	7
627	Newington	84	5
629	New Orleans	60	5
630	New York	96	7
631	North Hampton	42	1
632	Northport	52	2
635	Oklahoma	148	7
636	Omaha	56	4
637	Asheville	68	3
640	Palo Alto	135	5
641	Perry Point	62	3
644	Phoenix	17	1
645	Pittsburgh (HD)	44	1
646	Pittsburg (UD)	95	4
647	Poplar Bluff	57	0
648	Portland	86	13
649	Prescott	61	2
650	Providence	33	0
652	Richmond	97	3
653	Roseburg	87	3
654	Reno	31	4
655	Saginaw	85	2
656	St. Cloud	62	3
657	St. Louis	332	16
658	Salem	111	4
659	Salisbury	107	3
660	Salt Lake City	93	5
662	San Francisco	133	7

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION

Veterans Health Administration (VHA) New Patient Feedback Survey

BACKGROUND: The scientific literature has questioned the usefulness of satisfaction surveys on two issues. One is that satisfaction has a gratefulness component that upwardly biases the results. Second, general measures of satisfaction do not provide a specific operational focus for improvement efforts. Therefore, despite the high satisfaction scores we receive, satisfaction alone does not provide a powerful enough tool to accurately identify opportunities for improvement.

Quality is increasingly defined as meeting customer expectations. The research on measuring the experience of patients has clearly concluded that patient reports as well as their overall ratings are an effective method to systematically identify opportunities for improving the quality of care provided by healthcare organizations. We expect that the current changes proposed in VHA and the national healthcare system will make customer information an imperative in this competitive healthcare environment. If we are to compete effectively, we must make the improvements in our delivery system that are responsive to customer expectations.

The results from the current patient satisfaction survey, that has been in place since the 1980's, are uniformly good. While customer satisfaction has been high all these years, the information available from these surveys has not demonstrated opportunities for improvement. Therefore, the patient satisfaction surveys are undergoing major changes. The FY 1993 Patient Satisfaction Survey is attached for your review.

CURRENT STATUS: In order to provide VA Medical Centers with survey tools to meet these expectations, in 1992, VHA initiated a process to replace the current obsolete patient satisfaction surveys. The Picker/Commonwealth Program for Patient-Centered Care was identified as a state-of-the-art example of a patient focused survey design that could serve as the basis for redesigning the VA patient satisfaction surveys.

The Picker/Commonwealth approach to assessing patients differs from the traditional approach to these surveys by using focus groups of patients and their families to first identify what is important to them (rather than assuming that traditional areas of food, cleanliness, etc., has a high impact on their satisfaction or quality ratings). The results of this approach identified seven areas of concern to patients. These areas were replicated in focus groups of VHA patients held throughout the country. For inpatient care they are:

1. Respect for Patient Preferences.

2. Emotional Support.
3. Continuity of Care and Transition to the Community.
4. Patient Education.
5. Family Participation.
6. Communication with the Patient.
7. Physical Comfort Including Pain Management.

Questions exploring these areas from the Picker/Commonwealth survey were then adapted for use in VHA. The wording of the VA questions, however, maintained comparability to the Picker/Commonwealth instrument to allow comparisons between VHA and the private sector. These inpatient questions were piloted in a mail out survey to 11,714 recently discharged medical, surgical, and psychiatric patients at 20 VA Medical Centers throughout the country. Seventy (70) percent of all patients responded. The analysis of the pilot survey is now underway.

The inpatient survey is the first step in the three part inpatient, outpatient and long-term care surveys of our patients. The second step is the outpatient survey. VHA's emphasis on continuity of care within a managed care environment requires a strong customer feedback loop to ensure that we meet customer expectations and to be competitive. VHA is developing its outpatient survey as part of a consortium of the American College of Physicians, the National Association of Community Health Center, and Health Maintenance Organizations (HMOs) such as the Harvard Community Health Plan. The use of a consistent survey instrument will allow VHA to compare itself across different organizations and assess its competitive position in meeting customer expectations. The priorities for care identified by VHA patients in focus groups are again consistent with those identified by the cooperating organizations. They include those identified for inpatient care, but add the following areas for inclusion and emphasis:

1. Provider Continuity and Availability.
2. Timeliness of Access.
3. Coordination and Integration of Care.
4. Employee Courtesy.

The outpatient survey is being piloted at West Roxbury VA Medical Center clinics prior to system wide piloting and at Beth Israel Hospital in Boston.

The Long Term Care Survey will be piloted and implemented in FY 1995.

The priorities for care are customer defined standards that will enable VA medical centers to focus improvement efforts on these standards. The information feedback of VA medical center to VA medical center performance and private sector comparisons will enable VA medical centers to benchmark their performance and then work towards a competitive advantage in their local communities.

Patient feedback data will also be used with patient complaint data collected by VA medical centers to identify specific groups of patients to be surveyed locally as a follow up to the national survey or in response to locally identified issues associated with its strategic planning, competitive analysis or quality of care issues. For example, the surveys could be administered to cancer patients, patients from a specific geographic unit within its service area, patients within a certain age group, etc., to enable them to focus in on very specific locally defined survey groups.

Attachment

Department of Veterans Affairs

Memorandum

Date: February 15, 1994

From: Associate CMD for Quality Management (15)

Subj: Patient Satisfaction Survey FY 1993 Report

To: Under Secretary for Health (10)

Thru: Deputy Under Secretary for Health (10A)

1. Attached is the FY 1993 Patient Satisfaction Survey report. For comparative purposes, attention was given to the FY 1991 and FY 1992 findings.

2. The reduced sampling methodology implemented in FY 1993 indicated only slight differences in the results compared with prior fiscal years. However, for the three program areas surveyed each year at least 94 percent of the veteran respondents rated their satisfaction with the care provided by VA as favorable.

3. To improve the high quality of care to the nation's veterans, the Office of Quality Management is currently undertaking development of a new instrument that will be essential to providing reliable feedback from patients receiving health care in the VA. The Patient Feedback System will replace the current Patient Satisfaction Survey in the near future.

4. Questions concerning this report may be directed to Ms. Jackie McEwan, at 535-7348.

GALEN L. BARBOUR, M.D.

Attachment

VA FORM 2105

1

VA PATIENT SATISFACTION SURVEY

I. INTRODUCTION

This report provides a general overview of the findings during the FY 1993 PSS (Patient Satisfaction Survey) conducted at each VA medical center. These findings are based on comparative analyses of the average response shown for each standardized question and the percent of the total number of respondents under each rating category. Comparative analyses are within the three major programs (hospital, extended care and outpatient) at the national level. Also, included for comparative purposes, are data from fiscal years 1991 and 1992.

The Office of Quality Management is involved in replacing the current PSS with a tool developed to solicit patient feedback about their VA health care experiences and to improve validity, usefulness, ease and timeliness in reporting. To ease the workload burden until implementation of this new survey tool, each VA medical center was requested to conduct their Patient Satisfaction Surveys based on a reduced sampling methodology. This modification to the survey process began during the second quarter of FY 1993. The workload burden was reduced from 5 percent to a minimum of 2 percent and the frequency of reporting was reduced from quarterly to yearly. The survey process will continue in this manner until implementation of the Patient Feedback System.

The current Patient Satisfaction Survey design is so that analysis of the results for each VA medical center is primarily left up to local management requirements. In FY 1992, provisions were made available for VA medical centers to select a maximum of five questions from an approved generic list of facility-specific questions. These questions, distributed in conjunction with the three standardized questionnaires allow facilities to focus on identified problem areas. The overall average response ratings exclude responses to the selected questions. In FY 1993, forty-two percent of the 171 VA medical centers found the facility-specific questions to be useful.

II. VA ACUTE INPATIENT CARE

In spite of the reduction in the sample size during FY 1993, 42,199 patients responded to the acute care portion of the survey; thus, representing approximately five percent of the 910,000 inpatients discharged from hospital care. The average overall response rating[1] for inpatient care did not vary from 4.4 or 'GOOD' as indicated by the five possible responses presented in the questionnaires. Since the first quarter of FY 1991, "WARD CLERK" received the highest average response rating of 4.6 for courtesy and care given. Sixty-five percent of all the participating patients for each

[1]The "TOTAL AVERAGE" or overall average response rate is computed by dividing the total number of responses for all questions by the results of multiplying each rating number (1-5) by the number of responses for each rating category.

fiscal year responded to this question. This question received a rating of "GOOD" or "VERY GOOD" by at least ninety-five percent[2] of the total respondents.

Since the inception of the current survey tool, the "VARIETY OF FOODS SERVED" has received the lowest average response rating. Although only slightly lower than all other response ratings, a 3.9 average response rating for this question represented 97 percent of the total number of respondents to the survey.

Table 1, shows the national inpatient care average response rating and the percent of total patients responding to each question for the three fiscal years.

Although there was a decrease in the total number of respondents to the inpatient survey questionnaire mainly due to modifications to the sampling methodology, ninety-seven percent of the patients responding to the 38 inpatient questions continued to rate their facility "FAIR" or above. The table below shows the similarities in the overall percent breakdown for each rating category during the past three fiscal years.

RESPONDENTS TO INPATIENT SURVEY BY RATING CATEGORY
FY 1991 THROUGH FY 1993
(Percents)

RATING CATEGORY	*FY 1991*	*FY 1992*	*FY 1993*
1 - VERY POOR	*1.4*	*1.4*	*1.2*
2 - POOR	*1.9*	*2.0*	*1.7*
3 - FAIR	*8.5*	*8.7*	*8.0*
4 - GOOD	*33.0*	*33.8*	*33.1*
5 - VERY GOOD	*55.3*	*54.2*	*56.1*
TOTAL	*100.0*	*100.0*	*100.0*

For FY 1993, 3.4 percent of a total of 42,199 respondents to the inpatient survey indicated a need for assistance in completing the questionnaire. The remaining 96.6 percent either represented patients who did not require assistance (25 percent) or those who did not respond to this question (72 percent).

[2]Percents relating to specific response categories are computed by dividing the total number of responses for each response category by the total number of responses for a particular question, then multiplying by 100.

Based the survey results, only 24 percent of all patients who submitted an inpatient survey form and scheduled for discharge were scheduled to return for outpatient care. Of these outpatient care scheduled appointments, 82 percent were within two months after discharge, 14 percent were within three to six months and the remaining four percent, six months or more in advance. In the prior two fiscal years, more than half of the inpatients completing a survey form were scheduled for a return outpatient visit. However, for all three fiscal years, the percentage breakdown for return visits was the same.

The average age remained at 56 for the past three fiscal years. Even with the decrease in survey distribution, the proportion of the total respondents indicated as Prisoner of War (POW) veterans averaged two percent.

III. VA OUTPATIENT CARE

The number of respondents to the outpatient portion of the survey dropped 39 percent (from 201,458 in FY 1992 to 123,757 in FY 1993). As mentioned above, facilities were requested to obtain a minimum two percent sample of their workload. However, four percent of the approximately 3.2 million individuals who received outpatient care during FY 1993 responded to the survey.

For the past three fiscal years, the overall average response rating based on the 5 point rating scale was 4.3 "GOOD". Although only a slightly higher rating indicated, the question attaining the highest average response rating of 4.5 continued to be "YOUR DOCTOR'S ABILITY TO SPEAK ENGLISH" under B. GETTING CARE. This average rating has remained relatively unchanged. During FY 1993 those patients responding to this question represented 92 percent of the total respondents to the survey. Ninety percent of the respondents to this question gave a "GOOD" or "VERY GOOD" rating. The question, "INFORMATION YOU WERE GIVEN ABOUT DELAYS" under "A. CLINIC RATING" has received the lowest average response rating since the first quarter of FY 1991. For FY 1993 the average response rating for this question was 3.9 representing 83 percent of the total respondents to the outpatient survey. Of the respondents to this question 12 percent gave an unfavorable rating.

Table 2, shows the national outpatient care average response rating and the percent of total patients responding to each question for the three fiscal years.

Since FY 1991, 96 percent of the patients responding to the 30 outpatient questions gave ratings of "FAIR" AND ABOVE with a slight overall improvement indicated in the table below.

RESPONDENTS TO OUTPATIENT SURVEY BY RATING CATEGORY
FY 1991 THROUGH FY 1993
(Percents)

RATING CATEGORY	FY 1991	FY 1992	FY 1993
1 - VERY POOR	1.8	1.6	1.6
2 - POOR	2.6	2.4	2.3
3 - FAIR	10.9	10.6	10.0
4 - GOOD	38.3	37.9	37.4
5 - VERY GOOD	46.4	47.4	48.8
TOTAL	100.0	100.0	100.0

During FY 1993, five percent of the 123,757 total outpatients who responded to the survey indicated a need for assistance in completing the questionnaire. The remaining 95 percent of the respondents either represented those patients who did not need assistance (72 percent) or those who did not respond to this question (23 percent).

Sixty-nine percent of the total outpatient respondents were scheduled for return visits. At least 57 percent of those, were scheduled to come back within two months and the remaining 43 percent within three to six months or longer.

The average age of outpatient participates in the survey remained at 59. Of a total of 123,757, a slight decrease was evident in the proportion of former POW veterans participating in the survey (from 4.9 percent in FY 1991 to 3.3 percent in FY 1993).

IV. INTERMEDIATE OR NURSING HOME CARE

The number of patients responding to the survey and receiving intermediate or nursing home care decreased 43.8, from 17,068 in FY 1991 to 9587 by FY 1993. This dropped was an indication of the decrease in the sample size due to survey methodology and the limited survey population.

5

The overall average response rating for long-term care continued to be "GOOD" with a slight increase in the rating from 4.15 in FY 1991 to 4.23 in FY 1993. The highest rating of 4.5 was given for courtesy and care provided by the "WARD CLERK", under E. OTHER STAFF. Of the total submitted survey forms, the number of respondents to this question represented 77.3 percent of the total respondents in FY 1993. For both FY 1991 and FY 1992, this questioned received a rating of 4.4 even with the courtesy and care provided by the "VOLUNTEER" receiving the highest rating. The question asking whether the patient "LIKED THE VARIETY OF FOODS SERVED" under B. MEALS continued to receive a slightly lower average response rating. With 96.6 percent of the total patients surveyed responding to this question, 90 percent gave a favorable rating.

Table 3, shows the national intermediate/nursing home care average response rating and the percent of total patients responding for each question by the three fiscal years.

Since the onset of the PSS in FY 1991, the proportion of the total number of respondents who rated their VA facility "GOOD" or "VERY GOOD" increased from 81 percent to 85 percent. Despite the 44 percent drop in the number of respondents, as indicated in the table below, there remained evidence of overall patient care satisfaction.

RESPONDENTS TO INTERMEDIATE/NURSING HOME SURVEY
BY RATING CATEGORY FOR FY 1991 THROUGH FY 1993
(Percents)

RATING CATEGORY	FY 1991	FY 1992	FY 1993
1 - VERY POOR	2.0	1.6	1.5
2 - POOR	3.1	2.6	2.6
3 - FAIR	13.4	11.9	10.8
4 - GOOD	42.4	44.7	42.1
5 - VERY GOOD	39.1	39.2	43.1
TOTAL	100.0	100.0	100.0

For the first two fiscal years, those patients needing assistance in completing the questionnaire accounted for over half of the total respondents. In FY 1993, only 40 percent of the total respondents completed this question. Of those responding, 57 percent indicated that help was needed with the form.

Of the total extended care respondents, five percent were scheduled for treatment at VA outpatient clinics. Of those scheduled for outpatient care, 93 percent were scheduled for appointments within six months.

The average age remained at 67. The average number of former prisoner of war veterans who responded to the survey decreased from 5 to 2 per participating VAMC.

V. CONCLUSION

This report dealt with the Patient Satisfaction Survey data submissions from all VA medical centers during fiscal years 1991, 1992 and 1993. Since the inception of this survey process in FY 1991, the overall average response ratings for each of the three major programs, hospital, outpatient, and extended care collectively indicated that at least 94 percent of all veteran respondents rate their satisfaction with the care provided by the VA as favorable ("3-FAIR", "4-GOOD", or "5-VERY GOOD"). However, widespread feedback from the field has indicated that there is dissatisfaction with the current tool. The most prevalent concerns include its inability to detect significant opportunities for improvement, validity of the data and timeliness.

The Office of Quality Management has committed to developing a patient feedback system that will replace the Patient Satisfaction Survey. This new tool is expected to be as labor sparing as possible while providing statistically valid, reliable and clinically relevant information. Piloting of the new inpatient instrument in FY 1993 included twenty randomly selected Surgical Risk Assessment Study VA medical centers. Testing of the outpatient and long-term care instruments is scheduled for 1994. Piloting and implementation of the new tool is expected to occur for each program in an overlapping time frame. The goal for the new system is to automate as much of the process as possible.

TABLE 1

PATIENT SATISFACTION SURVEY - INPATIENT SURVEY RESULTS
NATIONWIDE TOTALS FOR FISCAL YEARS 1991 - 1993

COMPONENT	QUESTION	AVERAGE RESPONSE RATING * FY91	FY92	FY93	% OF TOTAL SURVEYS* FY91	FY92	FY93
A. ADMISSION PROCESS	1. PROMPTNESS	4.21	4.3	4.23	97.6	97.4	97.6
	2. STAFF COURTESY	4.44	4.43	4.46	97.5	97.3	97.6
B. ACCOMMODATIONS	1. ROOM CLEANLINESS	4.42	4.39	4.43	99	98.9	98.9
	2. NOISE LEVEL	4.06	4.07	4.11	97.6	97.7	97.8
	3. WORKING EQUIPMENT	4.53	4.54	4.58	97.5	97.6	97.7
C. MEALS	1. PROPER TEMPERATURE	4.07	4.07	4.13	98.3	98.3	98.3
	2. FOOD SERVER COURTESY	4.47	4.44	4.47	98.3	98.3	98.1
	3. VARIETY	3.93	3.92	3.97	97.3	97.5	97.4
D. PHYSICIAN	1. EXPLANATION OF CARE	4.43	4.41	4.43	98.3	98.4	98.3
	2. COMMUNICATION	4.54	4.51	4.53	98.4	98.4	98.4
	3. CONCERN	4.47	4.44	4.47	97.8	97.9	97.9
	4. CONFIDENCE IN DOCTOR(S)	4.46	4.43	4.46	97.5	97.5	97.5
E. NURSING CARE	1. RESPONSE PROMPTNESS	4.47	4.45	4.5	98.6	98.5	98.5
	2. CARE EXPLANATION	4.5	4.48	4.53	98.5	98.4	98.2
	3. CONCERN	4.54	4.52	4.57	98.2	98.2	98.1
	4. CONFIDENCE IN NURSE(S)	4.56	4.53	4.57	98.4	98.3	98.2
F. OTHER STAFF	1. CHAPLAIN	4.43	4.43	4.46	64.5	63.6	63.9
	2. CLEANING STAFF	4.4	4.37	4.41	83	81.8	82
	3. DENTIST	4.11	4.11	4.13	30.2	32.1	30.6
	4. DIETITIAN	4.38	4.33	4.37	70	68.9	69.5
	5. HEARING/SPEECH THERAPIST	4.19	4.18	4.23	19.1	18.4	18.7
	6. BLOOD DRAWER	4.41	4.4	4.43	78.5	77.5	77.7
	7. LIBRARY STAFF	4.33	4.31	4.36	27.7	27.1	27
	8. OCCUPATION THERAPIST	4.43	4.39	4.43	30.7	30.9	31.3
	9. PHARMACY STAFF	4.27	4.28	4.32	43.8	44.8	43.5
	10. PHYSICAL THERAPIST	4.44	4.41	4.48	30.1	30.3	30.9
	11. RECREATION STAFF	4.43	4.4	4.44	36.8	36.9	36.2
	12. RESPIRATORY THERAPIST	4.41	4.38	4.43	26.8	26.1	27.1
	13. SOCIAL WORKER	4.39	4.37	4.42	63.8	64.8	64.9
	14. VOLUNTEER	4.86	4.83	4.86	48.4	47.3	46.3
	15. WARD CLERK	4.6	4.57	4.61	66.2	66.6	66.4
	16. X-RAY TECHNICIAN	4.53	4.51	4.53	98.4	63.9	63.9
	17. OTHER STAFF	4.49	4.48	4.48	13.6	13.6	14.8
G. DISCHARGE	1. PROMPTNESS	4.33	4.33	4.36	78.5	77.9	78.6
	2. HOME CARE INFORMATION	4.49	4.49	4.52	76.5	76.6	76.3
H. OVERALL RATING	1. FACILITY CLEANLINESS	4.42	4.4	4.44	91.7	91.2	89.9
	2. CONCERN FOR PRIVACY	4.44	4.42	4.46	90.9	90.4	89.3
	3. OVERALL RATING	4.5	4.47	4.51	91.5	90.9	89.6
TOTAL AVERAGE		4.39	4.37	4.41			
TOTAL SURVEYS		49,284	61,353	42,199			

*Percent of Total Surveys = the number of patients responding to each question divided by the total number of completed surveys by fiscal year end.

TABLE 2

PATIENT SATISFACTION SURVEY - OUTPATIENT SURVEY RESULTS NATIONWIDE TOTALS FOR FISCAL YEARS 1991 - 1993

COMPONENT	QUESTION	AVERAGE RESPONSE RATING FY91	FY92	FY93	% OF TOTAL SURVEYS* FY91	FY92	FY93
A. CLINIC RATING	1. CONVENIENCE	3.94	3.96	4.01	97	96.4	94.5
	2. WAITING AREA COMFORT	4.14	4.16	4.19	97.6	97	95.6
	3. WAITING AREA CLEANLINESS	4.36	4.36	4.37	97.5	96.7	96.3
	4. PROMPTNESS BEING SEEN	3.81	3.87	3.93	96.5	96.7	94.5
	5. EXPLANATION OF DELAYS	2.74	3.8	3.89	84.8	84.1	83.3
B. GETTING CARE	1. EXPLANATION OF CARE	4.29	4.3	4.33	94.1	93.6	91.4
	2. COMMUNICATION	4.43	4.45	4.48	94.5	93.3	91.7
	3. CONCERN OF DOCTOR	4.35	4.36	4.38	93.5	94.7	90.5
	4. CONFIDENCE IN DOCTOR(S)	4.32	4.34	4.36	93.5	93.6	91.3
	5. EXPLANATION BY NURSE	4.29	4.31	4.34	93.9	94.9	92.7
	6. CONCERN OF NURSE	4.23	4.34	4.36	94.5	93.8	91.9
	7. CONFIDENCE IN NURSE(S)	4.33	4.36	4.37	93.8	94.6	92.7
C. OTHER STAFF	1. CHAPLAIN	4.31	4.3	4.33	23.6	20	18.5
	2. CLINIC CLERK	4.36	4.42	4.43	94.9	94.7	94.3
	3. DENTIST	4.14	4.16	4.19	23.8	26.8	19.2
	4. DIETITIAN	4.27	4.3	4.31	29.3	27.4	26
	5. HEARING/SPEECH THERAPIST	4.19	4.2	4.24	17.5	18.5	14.5
	6. LABORATORY STAFF	4.36	4.36	4.4	96.3	94.3	91.5
	7. OCCUPATION THERAPIST	4.31	4.32	4.36	18.4	14	13.7
	8. PHARMACY STAFF	4.11	4.13	4.17	96.5	96	93.9
	9. PROSTHETIC STAFF	4.19	4.31	4.34	16.6	18.1	14.3
	10. RESPIRATORY THERAPIST	4.29	4.32	4.36	17.9	17.6	16.4
	11. SOCIAL WORKER	4.21	4.22	4.26	23.8	21.9	21.2
	12. X-RAY TECHNICIAN	4.4	4.41	4.42	47.1	43.6	40.4
	13. OTHER STAFF	4.23	4.26	4.43	11.8	12.4	13
D. OVERALL RATING	1. FACILITY CLEANLINESS	4.36	4.36	4.37	98.2	98.1	96.4
	2. RESTROOM	4.37	4.38	4.4	96	97	96.8
	3. QUALITY OF CARE	4.41	4.41	4.43	92.5	92	91.4
	4. CONCERN FOR PRIVACY	4.34	4.36	4.38	90.6	90.4	78.9
	5. OVERALL RATING	4.37	4.36	4.41	94.8	94.3	93.1
TOTAL AVERAGE		4.25	4.27	4.3			
TOTAL SURVEYS		184,116	201,458	123,757			

*Percent of Total Surveys = the number of patients responding to each question divided by the total number of completed surveys by fiscal year end.

TABLE 3

PATIENT SATISFACTION SURVEY - INTERMEDIATE/NURSING SURVEY RESULTS NATIONWIDE TOTALS FOR FISCAL YEARS 1991 - 1993

COMPONENT	QUESTION	AVERAGE RESPONSE RATING FY91	FY92	FY93	% OF TOTAL SURVEYS* FY91	FY92	FY93
A. ACCOMMODATIONS	1. CLEANLINESS	4.22	4.23	4.24	96.5	96.2	96.6
	2. NOISE LEVEL	3.79	3.89	3.9	97.8	97.8	97.7
	3. WORKING EQUIPMENT	4.13	4.18	4.2	96.5	96.6	97.1
B. MEALS	1. PROPER TEMPERATURE	3.81	3.87	3.96	97.5	97	97.4
	2. FOOD SERVER COURTESY	4.27	4.28	4.35	97.3	96.9	97.5
	3. VARIETY	3.66	3.75	3.8	96.8	96.3	96.6
C. PHYSICIAN CARE	1. EXPLANATION OF CARE	3.93	4	4.06	96.2	96.4	96.6
	2. COMMUNICATION	4.24	4.25	4.28	96.3	96.4	96.7
	2. CONCERN	4.03	4.09	4.15	94.3	94.8	94.7
	4. CONFIDENCE IN DOCTOR(S)	4.08	4.11	4.17	94.5	94.9	95.1
D. NURSING CARE	1. RESPONSE PROMPTNESS	4.16	4.21	4.26	97.8	98.1	98.1
	2. COMMUNICATION	4.12	4.19	4.25	96.9	97.7	97.8
	3. CONCERN	4.21	4.25	4.32	96.9	97.7	97.7
	4. CONFIDENCE IN NURSE(S)	4.24	4.28	4.28	97.4	97.8	97.8
E. OTHER STAFF	1. CHAPLAIN	4.25	4.27	4.32	74.3	72.8	72.6
	2. CLEANING STAFF	4.25	4.27	4.32	89.7	87.8	88.1
	3. DENTIST	4.13	4.16	4.17	64.2	65	64
	4. DIETITIAN	4.09	4.14	4.21	80.8	79.8	80.5
	5. HEARING/SPEECH THERAPIST	4.08	4.12	4.17	35.3	36.1	34.8
	6. BLOOD DRAWER	4.16	4.19	4.21	75.2	73.4	74.1
	7. LIBRARY STAFF	4.14	4.16	4.2	36.2	36.1	36.9
	8. OCCUPATION THERAPIST	4.24	4.25	4.34	48.9	49.2	49.8
	9. PHARMACY STAFF	4.15	4.18	4.24	40.1	41.3	42.8
	10. PHYSICAL THERAPIST	4.28	4.3	4.37	55.8	56	56.3
	11. RECREATION STAFF	4.29	4.28	4.36	66.7	66.7	68.1
	12. RESPIRATORY THERAPIST	4.1	4.14	4.24	28.3	30.7	29.9
	13. SOCIAL WORKER	4.16	4.22	4.29	77.9	78.1	79.8
	14. VOLUNTEER	4.39	4.9	4.44	65.7	64	63.1
	15. WARD CLERK	4.36	4.4	4.47	72.7	73.8	77.3
	16. X-RAY TECHNICIAN	4.27	4.36	4.34	66.7	66	67.8
	17. OTHER STAFF	4.23	4.25	4.41	10.3	11	12.6
F. DISCHARGE	1. PROMPTNESS	3.96	4.1	4.13	23.9	25.7	24.3
	2. HOME CARE INFORMATION	4.11	4.1	4.28	23.9	26.8	23.6
G. OVERALL RATING	1. FACILITY CLEANLINESS	4.27	4.27	4.3	97.2	96.4	83.3
	2. CONCERN FOR PRIVACY	4.17	4.19	4.25	96.4	96.8	82.9
	2. OVERALL RATING	4.34	4.36	4.38	96.3	96.3	82.8
TOTAL AVERAGE		4.14	4.17	4.23			
TOTAL SURVEYS		17,068	15,503	9,587			

*Percent of Total Surveys = the number of patients responding to each question divided by the total number of completed surveys by fiscal year end.

OPENING STATEMENT
BEFORE
THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

REPRESENTATIVE TERRY EVERETT

April 20, 1994

Mr. Chairman, I want to thank you and the Ranking Minority Member of this Subcommittee, Mr. Ridge, for providing this forum to hear from our friends from the veterans' service organizations, the VA, and the GAO as they share with us the veterans' views on the current VA health care system and what role they feel the VA should play in national health care reform.

As I read over the advance testimony for today's hearing, I was struck by many of the comments made in the GAO testimony by veterans who are displeased with the quality of service they receive through the VA health care system. To me, the comment made by one veteran who said "it's like going to a bad Greyhound station" speaks volumes about the problems that many veterans face when they access their local VA medical facility. I realize that all veterans do not experience such difficulties and, in fact, that there are those veterans who are pleased with the care they receive. I am grateful for that.

However, Mr. Chairman, I must say in all honesty that we are fooling ourselves if we think a bit of spackle and paint and a couple of new community-based clinics here and there is going to make VA a more attractive option under a health care system, as proposed by President Clinton. There are much larger issues at stake than mere physical facilities and we must all work together to ensure that our Nation's veterans are given the best care possible.

I would like to extend a warm welcome to all of you this morning and we look forward to your testimony.

STATEMENT OF THE HONORABLE SPENCER T. BACHUS, III
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
VETERANS' PERCEPTIONS OF VA HEALTH CARE
APRIL 20, 1994

Mr. Chairman,

Thank you for holding this hearing today. As the health care reform debate continues, it is important for Members of this Committee to hear from veterans.

Veterans have a unique health care system, and this Committee has spent a lot of time hearing about its successes and failures. After reading today's testimony, I believe the key to reforming Veterans' health care is to focus on "customer service".

The VA must continue to improve the way it treats its customers - veterans. "Customer service" is an important part of any business that wishes to remain competitive. The VA has long had a captive clientele of veterans - millions more than they have been equipped to serve. Those who serve veterans' health care needs must keep their customers' needs in mind if the VA is to become a viable alternative for our nations' veterans - under whatever plan becomes law.

Under the Clinton plan, the VA would be required to attract veterans to their facilities. Cost savings incentives alone would be insufficient. Eligibility reform would determine the future clientele of the VA system. Consequently, the VA would be faced with the burden of providing a wider range of services to a broader population which may eventually include spouses and dependents.

No matter what health plan passes, there is a need for the VA to bring existing facilities up to par with their private sector counterparts and make services geographically accessible to more veterans. Veterans need to feel welcome in their facility - not wait all day for an appointment, wait for months to see a specialist, become entangled in the myriad of bureaucracy and paperwork, or be treated rudely by an overworked staff member.

Mr. Chairman, the surveys presented by some of the Veterans' Service Organizations indicate that there are many veterans who are amenable to the VA health care system. There are, however, many questions that have been left unanswered by H.R. 3600 - questions that must be successfully addressed in order to attract veterans to the system. No one will be able to determine the fate of the VA health care system better than the veterans themselves. Their suggestions may be the key to the future welfare of the VA health care system.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 8:30 a.m.
Wednesday, April 20, 1994

VETERANS' HEALTH CARE

Veterans' Perceptions of VA Services and Its Role in Health Care Reform

Statement of David P. Baine
Director, Federal Health Care Delivery Issues
Health, Education, and Human Services Division

GAO/T-HEHS-94-150

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss veterans' perceptions of the current veterans health care system and their opinions about the future role of the Department of Veterans' Affairs (VA) under health care reform. My testimony today will be based on the preliminary results of a series of focus group meetings with veterans we held at your request.

Before I discuss the results of the focus groups, let me tell you a little bit about how we conducted the focus groups and some of the limitations in how the results can be interpreted. Focus groups are basically small groups of people who get together to talk about a given topic--in this case, veterans' health care. A specially trained moderator conducts the meetings, posing broad discussion questions, but essentially allowing focus group participants to discuss the topics among themselves. Focus groups provide a range of views on a topic, but the results cannot be quantified and are not necessarily representative of the population as a whole.

Among the topics discussed in our focus groups were veterans' views on

-- the reasons and extent to which they use VA health care services;

-- their overall satisfaction with the care VA provides;

-- the need to maintain a separate VA health care system;

-- the question of whether the VA health care system should be expanded to cover dependents;

-- the issue of whether VA should set up managed care plans to compete with private sector plans, and the potential competitiveness of VA plans;

-- the factors they would consider in deciding whether to select a VA health plan; and

-- the ways in which VA could be changed to make it a more competitive provider.

These topics were discussed with groups of veterans with service-connected disabilities, veterans with low incomes, veterans with higher incomes, veterans who are Medicare eligible, women veterans, and veterans who live more than 40 miles from the nearest VA health care facility. For each category of veteran, we met with both veterans who currently use VA--or have used VA within the last 3 years--and veterans who do not use VA facilities. A total of 127 veterans participated in the 14 focus group meetings we held in Baltimore, Charlotte, Denver, San Francisco, and Martinsburg, West Virginia.

I would like to depart from the usual manner of our testimony. Instead of paraphrasing the views of the veterans, we have prepared a tape of excerpts from the focus groups to allow the veterans themselves to present their views.

In summary, the views of the participants were as diverse as the veteran population itself. While the views expressed were varied and may not be representative of the veteran population in general, several themes seemed to emerge:

-- Veterans, other than those without health insurance, seemed to use VA only for certain services, such as treatment of service-connected disabilities, rather than relying on VA for all of their care. This fact has important implications for health care reform because such veterans would be required under the proposed Health Security Act to choose either VA or another

health plan to provide all of their comprehensive health care benefits. For example, veterans who currently use VA only for treatment of their service-connected disabilities may no longer be able to obtain such treatment from VA if they enroll in a non-VA health plan.

-- Veterans' satisfaction with VA health care varied by location, but focused mainly on poor customer service. Not surprisingly, veterans in cities having veterans' facilities with good reputations for customer service also expressed more interest in enrolling in VA health plans. The reputation of individual facilities will likely be a significant factor in determining whether veterans stay with VA under health care reform.

-- Focusing exclusively on customer service issues may ignore another set of concerns. Veterans perceive that the care offered by VA can be erratic, and some question care offered by facilities in other locations. These veterans may have direct experience with different facilities or may be relying on anecdotal information. Whether groundless or not, veterans' misgivings about the quality of care rendered will affect VA's ability to compete in a reformed system.

-- Apprehension about change was a recurrent theme running through the focus groups. Veterans expressed concerns that changes could diminish or eliminate veterans' health benefits, that allowing dependents to use VA facilities could detract from care for veterans, that VA would lose its individuality and its focus on the special health care needs of veterans, and that veterans who are dependent on VA would be hurt emotionally. Such veterans generally expressed a desire to maintain separate VA health care facilities under health reform, seeing it as a tangible symbol of the nation's commitment to its veterans.

-- Other veterans did not see a need to maintain separate veterans' health care facilities, as long as veterans were given a viable alternative. These veterans suggested options such as VA becoming a payer rather than provider of services. The primary concern of this group was that veterans be given something of value equal to what they have now.

-- Veterans frequently indicated that the health care needs of veterans with the most serious service-connected disabilities should be VA's highest priority. Veterans with post-traumatic stress disorder, spinal cord injuries, illnesses possibly related to exposure to Agent Orange, or illnesses possibly related to service during Operation Desert Storm were cited as deserving special attention.

At this point, I would like to present the veterans' views of the VA health care system and its potential role in health reform.

EXCERPTS OF VETERANS' COMMENTS
MADE IN FOCUS GROUPS

GAO COMMENTATOR: WHY DO YOU CHOOSE TO GET HEALTH CARE FROM VA?

Well, I'll tell you, I don't have any insurance at all, nothing. That's the only hospital I've got to go to for anything.

I'm the same way.

I mean, whether it's service connected or if I get sick or hit by a car, that's the only place to go. I'm homeless, unemployed.

I use the VA as a safety net. If I am working and if I am covered with insurance, I will not use the VA; I will use my private insurance. But if I become unemployed, that is my safety net by going to the VA hospital.

The only thing I use the VA for is strictly on the things that were service connected. I don't use them for anything else. I have my own private doctor outside of the VA for all other medical purposes.

It's the VA's responsibility to take care of those injuries that you received in the war, not your insurance company's.

I'm not going to take my problem to somebody else when the military, VA, is responsible for it. You're going to see me today, or you're going to see me every day for the next 6 months, whatever it may take, because it's your responsibility.

GAO COMMENTATOR: HOW WOULD YOU DESCRIBE THE VETERANS' HEALTH CARE SYSTEM IN ONE OR TWO WORDS?

Caring and hopeful.

Big and slow.

Dedicated and helpful.

Time-consuming.

Good service.

It's expensive to the government.

Uncaring and case hardened.

Very slow and an old folk's home.

Administratively bogged.

Difficult and overcrowded.

Getting better.

A lot of government bureaucracy.

Underfunded.

Secretive.

GAO COMMENTATOR: ARE YOU SATISFIED WITH THE CARE YOU GET FROM VA?

The main thing is you have to wait. You have to wait. I used to get mad, but then it dawned on me, hey, this is free.

Seems to me like they do research on the veterans, and then the good from it goes somewhere else, and then they raise your insurance policy premiums.
One thing that I dislike about the Veterans' Administration--the whole system--is they reward you for not getting better...If I don't get better I've got free medical for the rest of my life. If I get worse, I get more money every month. Is that a real incentive to get better? Not at all.

What we need as older women are glasses, [a medical service that is] not service connected; dentures, not service connected; feet with corns and bunions and things like that, not service connected. So the things we need as older women are not available to us.

I'm happy and I am satisfied. I've been in the system--I'm 100 percent through the VA. I've used their system since 1978. You have to wait a long time...I'm just happy that I'm seen...I've just had a good experience.

I've been in the VA hospitals all over. I went up to Salisbury three times. I took my card and threw it on the desk and told them...I will never come back in that hospital again. I go to Columbia all the time. I was in the VA facility at Audie Murphy in San Antonio, Texas. I was in the VA facility in Dublin, Georgia, and I have never seen anything like that mess up there in that place. They need to close that hospital. Or go in and fire everybody in there and put somebody in there that will run that hospital and treat those veterans like they need to be treated.

The attitudes as far as being in a new facility. [refers to new facility in Baltimore] I put it to the people like this: whether it's a new facility or the old facility, you've got the same jackrabbits running through there. So what was down in Lock Raven [recently closed facility] is definitely up at the new hospital.

GAO COMMENTATOR: HOW WOULD YOU DESCRIBE THE CUSTOMER SERVICE AT VA?

Down in Washington, you pretty much have to wait on yourself, making your own beds and everything. Because I've been there--well, I've been there months at a time and pretty much had to take care of myself, make my own beds. They bring the sheets and lay them there and if you didn't make it, it wouldn't get made.

They treat you like you're a charity patient...When I walk in there, I don't want to be ignored: I want to be treated like I'm a human being. They are there because I have to be there. If I don't have to be there, then they have no jobs.

They try to make it as difficult for you as possible. They have lost the attitude of service. You are just a number.

GAO COMMENTATOR: HOW CONVENIENT IS IT TO OBTAIN CARE FROM VA?

If you go down there without an appointment, you can wait all day. You might have to wait until some time at night just to see a doctor.

Out at VA you go to one place and sit there for 20 minutes reading the newspaper. You move down to another spot for 20 minutes reading the newspaper. Pretty soon you almost miss lunch, and you feel like leaving. I don't know. I don't understand why it has to be that way.

There's no parking, period. You park 20 miles away. Walk over and then get your appointment made.

That's why everybody is there early. A lot of people are there early just so they can park...

I see it all the time. People have to drop them off, then go park the car and come back, and sometimes, almost an hour, there's this poor guy sitting in a wheel chair.

GAO COMMENTATOR: DO VETERANS NEED A SEPARATE VA SYSTEM?

There are things that happen in a war that don't happen any place else. And if you don't have a VA facility to take care of those veterans, you send them into a general public hospital. They won't have any idea of what to do.

I really think they could better serve the veteran if they would abolish all the hospitals, tear them down, get rid of all the overhead. You can't imagine how much money they spend all over the country every year to operate the VA. Just take that money and put the guys in a regular private hospital.

What we are saying is that the VA would become an insurance. Instead of giving service, it will provide the payment for the service...They would administer the insurance portion of it. They wouldn't be the care givers.

If you eliminate all the VA hospitals, you have to give veterans that have to use them a viable alternative.

My belief is that they could give them better care, because they would have more money.

And certainly the guy would have a more cheerful atmosphere in a private hospital than you would in a VA hospital.

I see nothing wrong with being incorporated into one big deal, as long as I got the same value as I get now.

If we take the VA away, what else is next? They are trying to lump us all in with everybody now that have never went to war, never got hurt. I feel like you keep the veterans' benefits separate. If they don't, we're going to lose them.

GAO COMMENTATOR: SHOULD VA OFFER CARE FOR VETERANS' DEPENDENTS?

If you are saying, well, you're going to have to make one decision, are you saying we make that one decision just for our personal needs? Or are we making them for our family's needs? Because for family's needs, if it's our family needs, "bye-bye VA," because I've got to take care of my family.

I have no problem with the VA taking care of families but I don't want to see it at the expense of veterans who earned it, either.

They're going to be offering well-baby clinics. Is that going to detract from someone getting in for a neurological problem? I'm uncomfortable with that.

I can't see my wife going to the VA hospital, period. And I can't see the kids going.

There's a lot of things in the VA hospital I wouldn't bring my kids in to see. I mean it would totally--you know, we'd walk in the door and then all of a sudden you've got about three or four people screaming at the top of their lungs or talking to themselves.

It's like going into a bad Greyhound station.

The VA was created to take care of the individuals who bore the brunt of the battle, not for my wife and not for my kids.

GAO COMMENTATOR: UNDER ONE HEALTH REFORM PROPOSAL, ALL CITIZENS WILL BE ABLE TO CHOOSE A HEALTH PLAN IN THEIR AREA. VETERANS WILL HAVE ONE ADDITIONAL OPTION IN THAT THEY WILL BE ABLE TO SELECT VA AS THEIR HEALTH PLAN. VETERANS, LIKE OTHER CITIZENS, MAY BE RESTRICTED TO USING ONE HEALTH PLAN EXCLUSIVELY. AS A RESULT, VETERANS MAY NO LONGER BE ABLE TO PICK AND CHOOSE AMONG THEIR DIFFERENT INSURANCE PLANS.

GAO COMMENTATOR: SHOULD VA SET UP MANAGED CARE PLANS TO COMPETE WITH THE PRIVATE SECTOR?

I would not go to the VA if it became like an ordinary place...a one-size-fits-all institution.

VA's going to be in the same business, with an advertising budget and marketers and the whole bit. Is that where we want VA to go? They were not set up to compete with a private HMO [health maintenance organization] company. If they start doing that, does that dilute what they were chartered to do when they were established, which was take care of disabled veterans? I don't know that they should be competing.

I don't know that the veterans wouldn't get lost in the shuffle or the bottom line.

People made sacrifices, commitments, and did things based on a certain level of understanding, and if you're going to change it, okay. That's certainly the Congress' right to change it, but they shouldn't change the deal they already cut with people in the room.

[For VA to compete]...that would be a couple more billion dollars thrown in the trash can...But it's a big black hole. It's a lot of money thrown down the drain. I'm sure that they could--I wonder what the studies say, but I'll bet that if they just paid the insurance premium on each veteran that went to the VA hospitals, they would have a cost savings--a measurable cost savings.

And now we're turning them into just another doctor schlep outfit. They're out there

schlepping for more patients so that they can dilute what some of these guys need.

I also say that I don't want to give away what I have. I would like to see the VA stay the way it is.

I don't even think it should become an option. It's an entitlement. You should have an option of going to the regular insurance plan everybody else has, and you should also have the entitlement of going to the VA if you so choose.

GAO COMMENTATOR: COULD VA EFFECTIVELY COMPETE WITH PRIVATE SECTOR PLANS?

I think that would be a lost cause.

If Lee Iaccoca can take the Chrysler name that was in the toilet and bring it back up, then they can do the same thing with the VA.

I think it is logical to conclude that the Veterans' Administration doesn't really have a reason to exist in terms of cost benefit...I would have to think seriously about is whether or not eliminating the Veterans' Administration health care also eliminates the symbol of responsibility to veterans who had service-connected problems. In balance, I don't know which way I would go. I know which way is logical, but the country is run on politics. Eliminating the symbol possibly is dangerous, so I don't know.

I still think that there are a lot of veterans that are probably inefficiently warehoused in veterans' hospitals--that are there permanently. Where are they going to go?

I think emotionally it would hurt one group--a group of veterans that have been dependent on that [the VA]. That's their security, and I think it would be devastating to those people that have been using VA all along.

GAO COMMENTATOR: WHAT FACTORS WOULD YOU CONSIDER IN SELECTING VA FOR YOUR HEALTH CARE?

A lot of people are going to look into reputation. A lot of people who have already been to the VA, to the bad ones in particular, are going to take into consideration how they were treated at the VA before. They're going to think about this. They're going to say, do I want to go back to that same damn system again? No. They're going to say no.

The VA hospitals are in sympathy with our particular needs. If we went to outside providers, we would have to start from scratch to explain to them what our particular problems are...I think we need to--to maintain the veterans' hospitals.

I really think that you guys need to look at the connection between politics and what happens with Congress and the VA hospital...When they say, "cut the budget," what ends up happening? The question really is related to disconnecting veterans' care from the whims of politicians.

GAO COMMENTATOR: IF YOU WERE SECRETARY OF VA, HOW WOULD YOU CHANGE VA TO COMPETE IN HEALTH CARE REFORM?

He's got to sell the idea, he's got to market the whole thing. He's got to attract good doctors, and then tell the people that are out there we got great doctors, and then bring in the people. Anything a business would do. What would Kaiser do? He should ask himself every day, what would Kaiser do, what would Cigna do, what would anybody else do that's in the business.

To streamline the outpatient system. I think that that's where they're really overloaded is outpatient clinics.

For the VA to get into contention as a runner in this business of providing health care to the people out there, it's going to have to improve its image.

I'd like to see every one of those people fired.

I would certainly allow autonomy. For example, if in Prescott, Arizona, their VA had all rural people far away, I would develop some kind of service that could get out to those people. If I'm in downtown San Francisco, or someplace where, you know, I think in Seattle, they have one downtown. Maybe there is a different kind of service I would provide, but I would try to make sure that my local administration had some kind of autonomy to service their populations, whatever they have to deal with.

The VA hospital here has a good reputation. Other VA hospitals don't have such a good reputations, yet they're all in the same plan. Somebody really should get around and look at them all and say, you know, this is "good," "what you've got stinks and get rid of it," and "mimic this better and do more like this."

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In summary, veterans expressed a wide range of views about the most appropriate role for VA under health reform and about the care provided by VA facilities. While their views may not be representative of the nation's 27 million veterans, many of the concerns expressed--such as excessive waiting times and poor customer service--have been the focus of prior GAO reports and hearings by this and other congressional committees. VA should consider such improvements as a necessary ingredient for competing successfully in a reformed health care system.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions that you or the Subcommittee may have.

STATEMENT OF JOHN R. VITIKACS, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
APRIL 20, 1994

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to present testimony on veterans' perceptions of the present VA medical care system and their views on the future of VA medical care.

Mr. Chairman, at the outset, we wish to commend Secretary Brown in his efforts to educate Veterans Health Administration (VHA) employees to the concerns and problems of veterans. The Secretary's "Putting Veterans First" campaign is no different today than the effort undertaken nearly 50 years ago when then VA Administrator General Omar N. Bradley stated, "We are dealing with veterans, not procedures: with their problems, not ours." It seems that in the interval between these two administrations, veterans' sacrifices and concerns have become less conspicuous to the American public.

Today, this Subcommittee is seeking answers to many theoretical questions concerning veterans' perceptions of the future of VA health care. The American Legion has not conducted a market survey of veterans' attitudes toward VA, nor can we categorically speak for all veterans. We will share with you, however, our concerns about the present VA health care system, based on direct observations and through anecdotal information provided by veterans.

Mr. Chairman, the VA health care system has many strengths and weaknesses. Over the years, VA has developed a first rate medical care system, limited only by constrained resources. The primary question of how veterans view the VA is communicated in terms of "the process versus the end-product". To many veterans the "process" is extremely complicated and time-consuming. Eligibility for VA health care is so restrictive and convoluted, that few veterans truly understand the rules that regulate access to care. Few veterans really understand that a VA medical center may have empty beds, not due to a lack of patient demand, but because the facility does not have sufficient resources to provide care to all who seek treatment. Veterans are confused when they learn they are eligible to be treated for a certain condition as a hospital inpatient, but they are not eligible to receive less costly care for the same condition as an outpatient. Under health care reform, VA will be challenged to attract as patients, veterans who have previously been denied care or have been treated with a less than kind attitude.

The American Legion is aware of many veterans who are very complementary of the care they received in VA. Conversely, we are also aware of many veterans who, for one reason or another, have developed a poor image of VA health care. Many of the unfavorable opinions held by veterans of VA are justified on an individual basis. Some veterans may never be persuaded to give VA a second or a third chance. However, with impending health care reform, VA has an opportunity to conduct educational and informational outreach to many veterans, both male and female, and perhaps dependents of veterans, to offer them health care which can be as first-rate as any offered by other health care providers.

Over the past year, The American Legion has testified before various Congressional committees concerning its views on VA's role in national health care reform. We believe the Congress has an opportunity, via health care reform, to correct the many inconsistencies which regulate eligibility for access

to care. By adopting the various recommendations set forth in **An American Legion Proposal To Improve Veterans Health Care,** among other helpful proposals, veterans' perceptions of the VA health care system can become predominately positive.

In addition to legislative and regulatory changes, VA must undergo a major "cultural" renaissance. It can no longer be business as usual when it comes to the way veteran patients and their families are treated as they approach VA for service. There must be a focus on making those folks feel that VA exists to serve them and to care for them, simply because it does. If the veteran patients go away, VA goes away as well. The business posture assumed by VA must be one of dedicated customer service. Many veterans and some VA employees object to the use of the word "customer" when referring to receipt of care in VA. However, as in any situation wherein a business relies upon the consumption of their services by others for its continued existence, that consumer is a "customer." Truly a veteran first, but a customer as well. The cultural changes must cross all organizational lines. There must be a change in attitude, environment, acceptability and availability of service and amenities so that the veterans health care experience becomes more than just tolerable. These types of change cannot be regulated or legislated. They must come from within VA through education and example.

It is difficult for veterans to believe that the nation will maintain its special commitment to their health related concerns when, among a myriad of health care reform initiatives introduced in the Congress, only one - H.R. 3600, addresses the eligibility and financial reforms needed to enable VA to chart a new beginning. The American Legion is rather dismayed when, upon contacting the sponsors of various health reform bills to discuss VA's role in national health care reform, little or no consideration has been given to VA. That leads us to believe that few members of Congress, outside of the members representing the Congressional Committees on Veterans Affairs, have tangible knowledge of the many contributions VA has made to the collective health care system of this country.

Today, the large majority of VA patients are service disabled veterans, or financially indigent veterans. We cannot begin to guess how many current VA users will decide to use non-VA facilities, given a choice under health care reform. The issues of relative access to care, the degree of primary care and specialty services available, appointment and waiting times to see a health professional, out-of-pocket costs, and the veterans identification with the VA as a special benefit earned in service to their country, among other factors, will all play a role in determining how eagerly veterans respond to a reformed VA hospital system.

The answers this Subcommittee is seeking on how veterans will view a reformed VA medical care system, and how they will respond in kind, depends largely on the shape of new legislative authority regulating a reformed VA, brought about through health care reform. Many questions concerning what standard benefits package will be offered to veterans through VA still needs to be determined. Other issues such as the premiums, copays or deductibles, charged to discretionary care veterans still have to be set. Until we see what final health reform bill emerges from the Congress, it is difficult to assess its impact on VA. We do believe, however, that if the reform of the VA health care system is accomplished with careful consideration to all of the issues the Legion and other veterans service organizations have testified to over the past year, we feel confident that a better, more responsive VA will emerge.

Veterans care about the same issues as all Americans when it comes to making health care decisions. These include: quality of care, convenience, professional courtesy, cost, timeliness of care, and other like factors. The judicial use of

the Health Care Investment Fund proposal contained in H.R. 3600, can help VA develop needed primary care clinics closer to veterans in rural and urban areas. It makes no sense to The American Legion to require VA to reduce up to 25,000 VHA employees over the next five years, under the National Performance Review plan, at a time when VA is embarking on its most important reforms ever. In order for the VA of the future to be successful, it has to be competitive with other health care providers. In the view of The American Legion, the National Performance Review plan, if applied to the VA medical care system, will place VA at a great disadvantage right from the start of health care reform.

Mr. Chairman, The American Legion has heard from its membership that it wants the VA health care system, its affiliated academic and educational training programs, its research programs and its impact in every congressional district of this country to be improved and maintained. In the final analysis, it is up to the members of Congress to shape the VA of the future. The Legion has placed its proposal regarding necessary improvements to the VA medical care system before you. We are ready and eager to continue a dialogue with the Congress to ensure that the reforms about to be considered regarding the VA medical care system, are undertaken with a view to improving and building upon the many successes that VA medicine and medical research has experienced over the years.

Mr. Chairman, that concludes our statement.

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Statement of

Michael F. Brinck
AMVETS National Legislative Director

before the

House Veterans Affairs Subcommittee
on
Oversight and Investigations

regarding

Veterans' Perception and
Participation in Healthcare Reform

April 20, 1994

AMVETS

NATIONAL
HEADQUARTERS
4647 Forbes Boulevard
Lanham, Maryland
20706-9962
TELEPHONE 301-459-9600
FAX 301-459-7924
FTS 8-344-3352

Mr. Chairman, thank you for requesting AMVETS' views on reforming VA healthcare, its effect on veterans, their attitudes toward VA, and their participation in the process.

The questions you posed for our consideration are certainly relevant to VA healthcare reform. To answer most of those questions accurately will require a polling of our membership, and we are proceeding with a poll in the July issue of our national magazine. We will be happy to share the results of the poll with you when it is completed. Until that time, AMVETS hopes that you will accept our statements as generally reflective of what the national staff thinks veterans would want when reforming VA healthcare.

- *What do veterans think about VA healthcare and how do they compare it to community providers?*

Veterans believe the many facets of the VA medical system are generally equal to or better than their community providers. They want VA to be a modern, community-based, technically competent and compassionate medical system that understands that veterans' healthcare is their primary mission. Veterans take pride in a well-run VA facility and in the facility's contribution to their communities and the nation. They also think VA is infected with medical bureaucrats whose main job is to deny access to care. They are frustrated with absurd eligibility rules and surly employees. They are also quick to praise those who provide good service. In short, they view VA as <u>their</u> system, and resent what they view as a lack of understanding and compassion by Washington.

- *Rate VA relative to community providers for quality, convenience, choice, amenities, staff, cleanliness, cost, proximity, timeliness.*

While those veterans who are able to get into the system appear to be reasonably satisfied with the technical quality of care, there are major concerns about bureaucratic red tape, eligibility, distance, amenities and waiting times. Technical quality is as good as or better than non-VA. When one analyzes a scandal such as the patients who disappeared a VA mental health facility in Virginia, the fault is really one of poor management and supervision, not poor medicine; convenience is well below community standards; staff politeness relative to other sources of care is a difficult call, but anecdotes abound about surly staff; cleanliness varies but is usually directly related to housekeeping staff's concern about

providing quality service; proximity leaves much to be desired and may be a major competitive roadblock; timeliness is not up to community standards – waits for appointments are long, and waiting rooms are crammed on appointment day.

- *How will veterans respond to healthcare provider choices brought by healthcare reform?*

The question of choice is important. As envisioned in HR 3600, everyone's ability to choose will likely be limited in some way to a choice of systems or health plans - which may or may not include one's current healthcare provider. It is also obvious that much of America's medical system will be forced under managed competition and global budgets to move sharply away from the traditional fee-for-service method of delivery to a more group-based system not far-removed from the VA model.

VA must be allowed by Congress to adopt quickly those parts of private healthcare systems that appeal to most Americans – like community-based providers for primary care needs and family care. AMVETS feels that if VA transitions quickly to a system that is more community-based and sheds itself of the current eligibility rules which limit access, veterans will have a reasonable level of choice in making healthcare provider decisions.

- *Will current users remain with the VA system? Will non-users turn to the VA for care?*

According to VA statistics, of the 2.99 million applications for VA medical care last year, nearly 2.9 million were from mandatory category veterans. And of those, about 1.4 million were low income veterans. Only 73,000 applications were from discretionary category veterans. It is obvious that a large percentage of those seeking VA care do so because of the cost advantage VA offers and will gain broader access to the medical establishment under national healthcare reform.

There have been several studies regarding this question and since the results have varied widely, it is difficult to make a firm prediction. What is clear though, is that VA must get the eligibility reform sought by all the veterans service organizations and evolve to a more community-based system. AMVETS is confident that if you build a VA system that is veteran-focused, that provides local access, that treats a veteran's family, that promotes research into

problems either unique or highly prevalent in the veteran population, veterans will come.

Survival of the VA system requires giving as many people as possible a stake in its success. That is why it is necessary to bring VA out of its isolation and integrate VA medicine more effectively with the rest of the national medical establishment while at the same time retaining VA's dedication to caring for veterans. A community with a local VA "franchise" clinic or storefront has a stake in VA medicine. Local medical professionals then have a stake in VA medicine. The local pharmacy then has a stake in VA medicine. Local suppliers then have a stake in VA medicine. And most importantly, with eligibility reform, all local veterans have a stake, not just the few who live close enough to existing medical centers and are mandatory category veterans.

In short, the structure of the VA system will have a great deal to do with how many veterans choose the VA system. If it remains the bureaucratic, red tape-bound system available to only a very few veterans it is probable VA will become the source of last resort for those who are unable to afford care elsewhere or those who need the highly specialized care VA does so well. That model is not an example of a quality medical system.

- *What about dependent care?*

Under the current eligibility rules, few dependents are able to get care from the VA. Studies have shown that a veteran's spouse has great influence over the family's choice of healthcare provider. A VA health plan that accommodates dependents not only would create new revenue streams, but would also enlarge the stakeholder population and improve services for female veterans by creating the critical mass required for cost efficient care.

- *Will the private sector system look more like VA or will VA look more like the private system?*

As stated earlier, it is likely that private medicine will begin to look more like the group-based VA system. And hopefully, VA will begin to look more like the private system. With the exception on its emphasis on treating veterans and its cost advantages to mandatory category veterans, the post-healthcare reform differences between a VA system facility and a private facility should be transparent. In fact, the systems should often be the same facility or health professional.

- *Will half of current users change to non-VA providers under healthcare reform?*

It depends on the design of the VA system, as stated in previous answers.

- *Will a quarter of current users change to non-VA providers under healthcare reform?*

It depends on the design of the VA system, as stated in previous answers.

- *Will more veterans come to the VA under healthcare reform?*

It depends on the design of the VA system, as stated in previous answers.

Mr. Chairman, we have offered no hard data to you today, but will be happy to share the results of our upcoming poll. Like the launch of any new product, there are uncertainties that can only be answered once the product hits the shelves. The nation has invested significant (although insufficient) resources in caring for its neediest veterans, and those resources should be built upon, not junked in favor of a one-size-fits-all approach to the delivery of medical care. We look forward to assisting in providing solutions to reforming the way the nation upholds its commitment. That completes our testimony.

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF
TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
VETERANS' PERCEPTIONS OF HEALTH CARE
APRIL 20, 1994

Good morning, Mr. Chairman and members of the Subcommittee. We appreciate the opportunity to testify on veterans' perceptions of their health care in the community and in VA today. Veterans' perceptions as well as their *expectations* of health care are critical to the present and future ability to recruit and retain veterans, and possibly their dependents, in the VA medical system. We thank the Subcommittee for recognizing the importance of perception in making concrete recommendations to VA for its improvements. We also congratulate VA on taking some proactive steps in determining their information needs to enable them to improve the system for veterans successfully. Many of their findings were reflected by our own findings—some, however, were somewhat contradictory. We look forward to seeing results from the new hospital inpatient survey instrument in FY 1994 and those for other venues of care in future years. Hopefully, these tools will enable VA to critically assess their needs for significant improvement in areas that veterans who participated in our studies identified as problematic. We are also happy that the survey was designed to be flexible in responding to *local needs* for information. We hope that VA field staff have been actively involved in the development of these patient satisfaction survey tools and are satisfied that they appropriately meet the needs of local management. If it is true that "all health care is local," giving the field an accurate means of measuring their successes and needs for improvement is far more important than assessing the strengths and weaknesses of the system overall. We look forward to hearing far more from VA as their data collection efforts in this venture progress.

Paralyzed Veterans of America's Health Policy Department undertook two studies from which we will be primarily drawing our comments today. The first is a series of focus groups PVA commissioned from Shugoll Research. This study looked at several cross-sections of the veterans' community. In our analysis, we included current system users, lapsed users, and veterans who had never used the VA medical care system. We talked to female as well as male veterans, black as well as white, rural as well as urban, service-connected as well as nonservice-connected, and veterans of all ages and combat eras. We conducted a total of 14 of these discussion groups in six different locations representing the four Veterans Health Administration regions across the nation. While we do not purport that our attempt to be representative of cross-sections makes the results of our focus groups statistically significant, the consistency of their responses in different areas allowed us to note trends in veterans' attitudes toward health care and VA among regions and among groups of veterans whose familiarity with VA services differs.

The second source we base our testimony on is an in-house survey developed for PVA's membership, that is veterans with spinal cord dysfunction, examining their health care preferences. This membership survey polled 1,200 of our members between November 5 and December 31, 1993. We consider this second study to be statistically representative of the perceptions of our membership offering us a good balance for the anecdotal information collected in the focus groups.

Mr. Chairman, we are not here today to tell you that all is well in VA, but neither are we here to predict its demise — far from it. PVA's original *Strategy 2000* report proposed that because of unilateral shifts in patient treatment modalities, structural changes in the delivery of care and reorganization brought on by implementation of a comprehensive national health care reform, VA could lose up to 50 percent of its inpatient hospital beds and up to 25 percent of its current outpatient visit load. However, this so-called "worse case" scenario is no longer valid in light of the VA's incorporation into the fabric of current national health care reform scenarios. The original "worse case scenario" published in Strategy 2000 last year supposed three hypothetical conditions: 1. the standard benefits package for the national health care reform plan would be comprehensive and require minimal out-of-pocket expenditures; 2. VA eligibility would remain as it is today; and, 3. VA would continue to be underfunded. The *American Health Security Act*, as proposed by President Clinton, would significantly alter this scenario by allowing VA to provide the same basic benefits package as other providers at no expense to core-group veterans. VA will also be able to continue to provide additional services veterans are eligible for under Title 38, U.S. Code. It would also provide substantial funding for VA to invest in projects systemwide that will strengthen programs and enhance access to make VA a more attractive choice for veterans. The Clinton plan is a gamble, but it gives the VA the opportunity to render the "worse case scenario" obsolete.

Our analyses have given strength to this argument. VA appears to be delivering certain services very well and offering comprehensive coverage for services not readily available to veterans in the private sector, particularly specialized services for veterans with spinal cord dysfunction. VA does have its problems, however, not the least of which involve the way it is perceived externally. Perceptions may have ramifications for patient recruitment efforts as VA enters into competition, particularly in recruiting the non-user and lapsed user populations as the VA's own customer survey revealed. Unfortunately, Mr. Chairman, perception is just as important as reality for any individual making health care decisions. Anecdotal information is more tangible and accessible to many individuals than statistical truth. For example, letting a veteran know that all VA facilities voluntarily either meet or exceed quality standards set forth by the Joint Commission on Accreditation of Health Care Organizations will not be as meaningful as his personal knowledge of the time Uncle Charlie had to wait four hours to be seen in the ophthalmology clinic or how rude the clerk was the time his neighbor Joe went in with a slipped disk. It is also true that most individuals tend to weigh service issues (or hotel amenities) more than medical care issues in assessing the quality of care they received. This is true of veterans and non-veterans alike because laymen are not typically equipped with the type of information they need to make educated choices in health care consumption. Few understand the accreditation process for providers—either hospitals or physicians—and fewer still make decisions based on this knowledge. Service-related issues are far easier to understand and assess and contribute most directly to the patient's image of the provider. Bad news also travels a great deal faster than good and the media has ensured that VA has had more than its share of black eyes. VA should have long ago been more active in correcting its image problems and proclaiming its accomplishments. Image is a major hurdle for VA to conquer in establishing itself as a successful competitor in tomorrow's reformed health care system. In short, there have been multiple sources of bad news about VA without much good news to balance them... and VA does have good news to share.

PVA Members

Some of the best news we got from these studies, for example, is that, by and large, our members appreciate the services VA provides them. Both the focus groups and the membership survey identified a great deal of satisfaction with VA services received. Obviously, this response was not universal—it varies, particularly, from facility to facility. From the focus groups, however, it is apparent that our members are grateful that there is a resource available to them that understands the specific needs of patients with spinal cord dysfunction and addresses these needs in a comprehensive way. In San Diego, one of the four locations in which we spoke to our members, veterans are especially happy with the care and the facility. They complimented the nurses as friendly and intelligent and the doctors as caring and concerned. They praised the holistic approach staff used to rehabilitate patients—classes on life style issues, such as sexuality and diet, as well as helping patients relearn basic daily life activities. They complimented the effort staff exerted to channel patients through the system when they required care outside of the

center. Some stated that they had moved to the area to be close to the VA medical center there. They were, however, far from consistent in applying this positive view to other SCI centers in which they had received care.

Complaints from veterans with spinal cord dysfunction are primarily in the areas of service and accessibility. Their complaints are not trivial—particularly in their concern for accessibility to a provider who understands how to treat a spinal cord injured person. Some of our members protested that they were subjected to care from providers who knew virtually nothing about spinal cord injury, particularly in facilities without spinal cord injury centers. Focus group participants were particularly critical of residents in some academically affiliated VA medical centers who appear to be too anxious to use spinal cord injured veterans to satisfy their own academic requirements rather than to meet the patients' needs. Other members claimed that their centers knew how to treat injuries, but that it was extremely difficult to access the care because of cutbacks in clinic hours and staff. Still others complained of the staff's lack of regard for their needs and their general insensitivity, even hostility, at some centers. A few veterans distrusted care in VA medical centers, generally, and preferred only to receive prosthetics, orthotics and prescription drugs from VA. Even with these complaints, however, the consensus of all of the groups consisting of veterans with spinal cord dysfunction could find strengths in the system and looked for answers **inside, rather than outside of VA** to addressing whatever concerns they stated.

In our membership survey, a quantitative approach to addressing these same types of issues, we found relatively similar views. Views of our membership might be considered a "watermark" for assessing the attitudes of VA system users. Many of our members describe VA as their principle health care provider (63 percent). 85 percent of respondents indicated that they had received VA health care services in the last five years. These individuals are highly reliant upon VA for their health care needs; 71 percent, for example, used a VA facility for their last physical and 65 percent said they would use VA in the event of a serious illness. PVA's memberships VA utilization rates are consistently higher than those of other veterans service organizations. That our members express a general satisfaction with the VA system and a definitive desire to go to VA to receive specialized services over any other health care provider in the country speaks very well of VA. PVA members overall experience, because of this high utilization rate, is representative of multiple exposures to VA care and, therefore, their opinions can be considered extremely well informed.

Why do most of PVA's members choose VA for care and what would make them more likely to use it? According to both the anecdotal information collected from the focus groups and our membership survey it is for the specialized care they are fairly confident they will be able to receive there. According to our survey, veterans with spinal cord dysfunction also are far more reliant on some types of care at VA than others. Some of this variation may be due to variations in eligibility classification and individual needs. Most of those surveyed by PVA use VA for prescriptions, prosthetics, and rehabilitation. They are less likely to use VA for dentistry, for nursing care, and for psychiatric care. PVA members are most likely to be unhappy with VA as an inpatient provider because it is "inconvenient" or because staff lack SCI training in certain locations. Most of our members feel that VA's quality is slightly better than "the average community hospital," most significantly because of its superior technical capability and the expertise of the medical staff.

It is clear from the results of both our studies that VA should do more to sensitize staff—from physicians to residents to allied health professionals—to the specific medical care needs of veterans with spinal cord dysfunction. In academic centers, an assigned physician or case manager with expertise in handling spinal cord dysfunction should actively supervise all medical care delivered by residents or those less familiar with spinal cord dysfunction. It is also clear that services for these individuals need to be more readily accessible—both in terms of clinic availability (offering better clinic hours) and geographic distribution of outpatient clinics—to prevent conditions beginning to manifest in the spinal cord injured patient from becoming exacerbated. As is true for other patients, VA staff should be encouraged to be friendly and helpful at all times.

Other VA System Users

As mentioned earlier in this testimony, PVA focus groups attempted to look beyond its membership for anecdotal information that would allow staff to assess the best recommendations to make to VA for steering strategic planning efforts for the VA medical care system in the future. Like VA, our intent was to look at the potential market of veterans—both current users of the VA system and lapsed and non-users. Like VA, we found that VA's best potential market is those who have the most familiarity with the system—that is, those currently using the system and, perhaps also, their dependents. Some veterans who have fallen away from the system because of access issues are also eager to regain access to the system—in our groups this was particularly true of rural veterans (we happened to choose a community that was distraught over the recent closure of its VA satellite clinic). Regardless of past utilization, veterans without other insurance options were receptive to the idea of enrolling in VA health plans. Other veterans from our studies were not anxious to enroll. By and large, our discussions with lapsed users indicated that they were the least favorably disposed to enrolling in VA. Non-users did not have much familiarity with VA one way or the other, but negative portrayals of VA in the press seem to have hurt its image with these individuals. It is important to note, however, that most veterans want VA available for them if they need it, and most certainly for their comrades-in-arms who are presently using services, particularly for service-connected problems.

Compounding these problems is the fact that veterans have a poor understanding of who can use VA. The vast majority of veterans we interviewed were eligible **now** for VA services either by virtue of a service-connected disorder or by income level. Many did not know that they were eligible. Presumably VA would accompany their recruitment efforts with a broad-based effort to educate **all** veterans of their eligibility for enrollment.

Most often, resistance to the idea of using VA services came from the fact that it was not likely they would be able to choose their own physician. Choice of physician was of the utmost importance to veterans and this importance increased with veterans' ages and the presence of veterans or their dependents' special medical needs. Many veterans had established bonds with their community physicians that would be difficult to break. Many veterans claimed that even with significant financial incentives, such as lower premiums or copayments, they would not be parted from their physicians. Our discussions did not presume that VA would have considerable options for primary care in the community. This could conceivably include some of these community physicians and, if indeed, VA is allowed to contract for primary care in the community, perhaps some of these concerns would be addressed. Community provider options might also alleviate some of the concerns veterans expressed regarding VA care accessibility.

Many veterans identified the importance of having case managers (preferably someone of their choosing) who would be familiar with their case histories and provide care continuity by shepherding them through the system, helping them identify eligibility problems and simplifying administrative hassles. Case managers would personalize a complex, bureaucratic system for many veterans and enhance veterans' sense of accessibility to the system by allowing them a direct point of contact within the system should problems arise. Case managers do not have to be physicians although they should be actively supervised by physicians.

Veterans did identify the importance of cost and the breadth of covered services as playing into their considerations for health insurance. A considerable number of current VA users utilize the system now because it does not cost them anything. We would assume that many of these users would continue to use the system for the same reason under health care reform—even if out-of-pocket expenses for health care were subsidized for some low-income veterans. Indeed if the breadth of the benefits package increases and enrolled veterans gain access to all the services VA has to offer and if certain changes were made, some respondents in our membership survey claimed they would be willing to pay a reasonable premium. Most veterans want better coverage for optical care, dental care, prescriptions and long-term care. VA could capture a market that was actively seeking cost-competitive coverage, but it will first have to ensure that a reasonable premium for veterans will cover the costs of these services.

Lastly, all veterans highly value courtesy, respect, and communicativeness in their providers. There is little doubt that VA will falter under health care reform if staff do not promote themselves and follow through on its own motto of "putting veterans first." To be most helpful, staff must be motivated by a pervasive culture that awards innovation, a management style that encourages autonomy and supports patient advocacy, and sufficient resources to empower employees to do the right thing for their patients. Without these factors, VA will have to share the blame for its employees lack of responsiveness and sensitivity. To promote this sensitivity VA should consider sponsoring in-house customer service training and significantly improving incentive systems to reward desired behaviors.

Mr. Chairman, everyone knows that VA has an uphill battle to become fully competitive under any comprehensive national health care reform proposal, but it is nonetheless a battle that can be won, and probably with great success in certain areas of the country where VA is already a well integrated player in the community health care network. Veterans perceive quality where quality exists. Conversely, they will not be wooed with a glitzy advertising campaign in areas where VA facilities need significant improvement. Perceptions create their own reality and VA must be attune to the need to meet its users' expectations to enhance their perception of VA health care services received. To achieve this goal VA must become more service-oriented and better equipped to actively respond to their users needs locally. Without these improvements VA is likely to disband in some of its service areas. We at Paralyzed Veterans of America believe that veterans, especially those with spinal cord dysfunction, would suffer a major loss if this occurred. There is no substitute for a veterans' medical care system geared toward their special care needs and this is something *all* veterans perceive.

Thank you for the opportunity to testify today, Mr. Chairman. We will be happy to answer any questions you may have.

STATEMENT OF

DENNIS CULLINAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE ROLE OF VA WITHIN NATIONAL HEALTH CARE REFORM

WASHINGTON, DC APRIL 20, 1994

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million members of the Veterans of Foreign Wars of the United States I wish to thank you for inviting us to participate in today's hearing. Through the years the VA health care system has been of profound importance to veterans throughout the nation. In carrying out this nation's obligation o care for her military veterans in their time of need, the VA health care system has also proven to be of great service to all veterans.

VA contributions in the areas of medical research and education have been instrumental in making overall American health care and science the best in the world. Further, in caring for medically indigent veterans in a highly cost effective manner, VA has reduced the burden which would have been placed on Medicaid as well as other federally funded social services. The savings accrue to benefit the American taxpayer. In our view, there can be no doubt that the VA health care system will be a critical and integral part of any national health care delivery system.

The Veterans of Foreign Wars is committed to the premise that veterans, by virtue of the special service and sacrifice they have offered up on behalf of the national good, are entitled to special honor and recognition. The VA health care system--the world's largest integrated medical system--was created just for that purpose: to provide a special place where veterans exclusively would be provided treatment for their particular illnesses and injuries.

Over the years, the VFW has clearly and repeatedly articulated its objective that the VA health care system be maintained and enhanced so that all veterans who turn to VA will be provided the state of the art medical care that they need and have earned. In this regard, the VFW acknowledges that the Administration is putting forth

a national health care plan which provides for the retention of VA as an independent health care provider for veterans, and even provides the potential for its becoming the health care provider of choice for all of America's veterans.

Within the framework of the health care reform, the VFW will labor tirelessly to ensure that veterans retain their unique status among the nation's health care recipients, continuing to receive tangible evidence that their commitment to the country is recognized and honored.

The VFW strongly believes that the quality of care provided at many VA medical centers is not only comparable to the private sector, but in many cases superior. Because of veterans' special needs, the system has been compelled to develop innovative and cost efficient ways of delivering care. Given the provision of an appropriate adjustment period and sufficient funding to better employ its resources, we believe VA will be well able to compete within a fair and equitable health care market.

So long as VA is provided with the necessary funding and personnel to allow it to open itself up and care for the needs of all veterans, we believe the VA should be very successful in attracting veteran consumers of health care. We continue to urge the Administration and the Congress, however, not to forget the special needs and service of veterans, and the fact that VA will not be automatically transformed into the health care provider of choice for veterans--sufficient funding and other adjustments are absolutely essential for this to come about.

Mr. Chairman, this concludes my statement. Once again I would like to thank you and the other members of the subcommittee for your ongoing work on behalf of the well being of America's veterans. I would be happy to respond to any questions you may have.

HEALTH CARE REFORM

AS PRESENTED BY

HERB ROSENBLEETH
NATIONAL EXECUTIVE DIRECTOR

JEWISH WAR VETERANS OF THE USA

APRIL 20, 1994

BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE HOUSE VETERANS' AFFAIRS COMMITTEE

Chairman Evans, members of the Subcommittee on Oversight and Investigation, my fellow veterans and friends, I am Herb Rosenbleeth, National Executive Director of the Jewish War Veterans of the USA, an organization which is proudly approaching our Centennial Celebration in 1996!

During the past 98 years JWV has stood for a strong national defense and for just recognition and compensation for veterans. The Jewish War Veterans prides itself in being in the forefront among our nation's civic groups in supporting the well-earned rights of veterans, in promoting American democratic principles, in defending universal Jewish causes and in vigorously opposing bigotry, anti-Semitism, and terrorism - here and abroad. Today, even more than ever before, we stand for these principles.

Before presenting JWV's views on health care reform, I wish to express our organization's appreciation to you, Mr. Chairman, and to the members of this committee for holding this hearing so that veterans organizations can publicly state our positions on the subject of health care reform.

Mr. Chairman, the Jewish War Veterans of the USA has consistently supported and worked with the Veterans Administration - now the Department of Veterans Affairs - to maintain and improve the broad range of medical services provided to our country's war veterans by a grateful nation.

JWV has consistently maintained that the VA must remain a viable, independent health care system. JWV further believes that all honorably discharged veterans, both service-connected and non-service connected, should be provided the full range of health care services. This is especially true in today's drive towards universal health care. Should the nation elect to provide health care for all persons, then for sure our veterans should be provided with the full range of those services. JWV includes preventive care, adequate quality, and guaranteed long-term care in the requirements for veterans health care.

Mr. Chairman, JWV is not at all convinced that the VA will survive under current health care reform proposals. These proposals seek to have the mostly underfunded VA system compete against private health care plans that are better funded.

Over the past 25 years, veterans' programs have sustained a constant funding reduction. Overall, veterans' spending has declined from 4.4 percent of all federal outlays in 1977 to 2.4 percent in 1992. Under the Administration's current economic plan, another $2.8 billion in veterans programs will be lost during the next five years.

Despite recent funding increases in the VA health care budget, VA has not been able to keep pace with current eligible veterans' demand for health care. This is because VA has neither overcome earlier funding deficits nor been able to position itself for the challenges of caring for the older veteran. Year after year, the VA must reduce the numbers of veterans receiving health care in order to cover underfunded inflationary health care costs, new program initiatives, and personnel and supply cost increases. Virtually the only VA category of workload that has not been reduced over the past four years is the outpatient workload, and that has been flat-lined for the past several years. However, those veterans who are treated, are frequently forced to wait up to six months before they receive needed outpatient care.

PERSONNEL CUTS ENDANGER THE VA

JWV is strongly opposed to the 1995 Clinton Administration budget which requires deep employee cuts for the VA.

The $38 billion VA budget proposal calls for a net reduction of nearly 4,000 health care employees in fiscal year 1995 - the initial phase of an overall federal workforce reduction which would require the VA to slash more than 26,000 employees from its rolls over the next five years. Health care staff would bear the brunt of these cuts, since they account for approximately 90% of VA's workforce. It is without a doubt that these cuts will seriously hamper the VA's ability to provide health care and research to veterans and to compete under any universal health care plan.

JWV strongly believes this is an extremely ruinous policy. Forcing VA hospitals, clinics and nursing homes to reduce staff will

obviously deny health care to many more veterans. Furthermore, it will significantly weaken the VA's ability to compete under national heath care reform.

Indiscriminately cutting thousands of health care employees at this point, even before we have entered an era of health care reform, will effectively pull the rug from under the VA health care system.

CONSTRUCTION PROGRAMS

Recent appropriations for VA construction projects have not kept pace with existing demands.

Historically, the VA construction program placed greater emphasis on inpatient procedures, while overlooking outpatient capabilities. Currently, VHA is developing a National Health Care Plan to review each health care facility's mission, in terms of the number of inpatient beds, outpatient workloads, individual programs and staffing levels. Once this review is completed and the VA's Facility Development Plan is fully funded, a realistic priority-based construction schedule can be established.

Over the past decade, both major and minor construction accounts have been seriously underfunded. Money appropriated for minor/minor miscellaneous construction projects were diverted with the Department to help pay for other priorities. The non-recurring maintenance program has suffered a similar fate. Congress and VA must work together to reduce the tremendous backlog in minor/minor miscellaneous projects. VA has an aging medical infrastructure system that if is continued to be denied the necessary adequate construction funding, will continue to deteriorate and will not be able to support the required new program initiatives.

MEDICAL RESEARCH

JWV strongly opposes the Administration's FY 1995 recommendation to cut $41 million from VA medical research, an important recruiting incentive for health care professionals and a critical component of quality care.

JWV considers research to be one of VA's most important programs. During the program's 45 year history, VA-sponsored research activities have contributed to successful heart and liver transplants and to eliminating tuberculosis as a major public health problem. VA research has pioneered drug therapies for the treatment of schizophrenia, depression, hypertension and diabetes. VA-sponsored research has also been instrumental in developing the CAT scan and testing the cardiac pacemaker.

We believe quality medical care includes clinical care, medical education and research. The three functions are interdependent research programs and must not be allowed to deteriorate. The present and future quality of health-care and rehabilitation depends on the DVA budget being adequately funded for medical research, a great deal of which is basic research that benefits all mankind, not only veterans.

Mr. Chairman, we cannot expect veterans to sign up for VA health care plans unless we can be assured that the VA will get the resources to provide for their care on a timely basis. These resources must not only be included in the Administration's proposals, they must also clear both Appropriations Committees, and they must not be short circuited by OMB.

JWV strongly believes that if national health care reform is going to provide an entitlement for non-veterans, then this nation must do no less for those who have honorably served in our nation's armed forces.

My mail and telephone calls clearly indicate that most veterans who can afford to do so plan to use health care systems other than the VA. In my opinion, the dire predictions of the General Accounting Office and the Congressional Budget Office will prove correct. It will all depend on the quality of care and the access to that care which will actually be provided. Will the veteran get an appointment on a timely basis?

Veterans are being asked to sign up for a VA health plan without knowing what care will actually be delivered and without knowing the quality of that care.

Mr. Chairman, in my opinion, without adequate financing health care reform is a prescription for disaster for the VA. With VA hospitals short of personnel, behind civilian hospitals in construction and equipment, veterans who can afford to do so will not select the VA. Only by making the VA a first class system will there be any real benefit for veterans. Without adequate funding, health care reform will result in VA hospitals being used mainly by those who cannot afford to be in a civilian plan.

Mr. Chairman, I would like to reiterate my sincere appreciation to you for conducting this hearing and I welcome any and all questions you might have.

Vietnam Veterans of America, Inc.
1224 M Street, NW
Washington, DC 20005-5183

(202) 628-2700
(202) 628-5880 fax

STATEMENT OF

VIETNAM VETERANS OF AMERICA

Presented By

Linda S. Schwartz, R.N., M.S.N.
Chair, VVA Veterans Affairs Committee

Accompanied By

Kelli R. Willard
Legislative Assistant

Before The

House Veterans' Affairs Subcommittee On Oversight and Investigations

On

Veterans' Perspectives on VA Health Care

April 20, 1994

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Introduction

Mr. Chairman and members of the subcommittee, Vietnam Veterans of America (VVA), appreciates the opportunity to present its views on the issue of health care reform and veterans perspectives on VA health care. The issues before us today and those raised in your pre-hearing questions are inarguably the most important points for consideration in VA's planning for the advent of health care reform. Veteran users -- or non-users -- will ultimately determine the fate of the VA health care system.

Today, veterans who use the VA health care system generally do not give the service rave reviews. While there are select facilities, providers and programs within the VA which provide above average standards of care, the VA health system as a whole does not meet consumer needs in the areas of timeliness, ease of access, proximity, friendliness, convenience, choice of providers, amenities, etc. VVA is planning to survey our membership on these very issues in the next month and will be pleased to share our findings with the Committee.

VA Defines Quality

Part of the problem with VA health care, as we have previously noted before this Subcommittee, is that VA has traditionally defined its quality standards by its own criteria rather than that of consumers. VA has touted its health outcomes and JCAHO evaluations as comparable or superior to that of the private sector. While the figures are perfectly legitimate, these factors unfortunately mean little to veteran users of the system.

Most veterans who use VA health care services are not astute in health care or consumer issues; the typical profile of a VA patient is elderly, single, male, uninsured or underinsured, unemployed or underemployed. This is to a degree a voiceless constituency because these are generally not the veteran population who subscribe to veterans service organizations. Telling these veterans that VA is a high quality health care provider based upon these outcomes statistics means little. These veterans essentially have nowhere else to get health care.

The militaristic style and environment of the VA is tolerable for some men -- mostly the World War II vintage. But the fact that a majority of veterans presently eligible for VA health care by virtue of being service-connected disabled do not choose VA is an indication of the veterans' opinion of the care. More knowledgeable consumers find the absence of consumer-friendliness factors of patient care equally if not more important to defining health care quality, and consequently in provider choices.

Veterans' Perceptions of Quality

One of the most important and encouraging points in VVA's participation in the VA's Health Care Reform Project Work Group process, is that VA leaders have come to the realization that quality standards must be defined by the veteran consumer's perspective. No longer can the needs of bureaucrats, teaching affiliations and researchers be met at the expense of the veterans this system was created to serve. VA does recognize that if the VA system is to survive, it will have to match and compete with private sector customer service standards.

Certainly when asked directly some veterans will say they feel the quality of VA health care is good. At the risk of being cynical, however, one must evaluate these responses with consideration of the individual's viewpoint. First, the veteran should be asked if he or she actually uses VA health services themselves, if they use VA regularly, and if the individual gets health care services anywhere else. Also, the veteran should be asked if he or she is fearful of retribution from VA medical staff if an unfavorable review is given.

While veterans are not necessarily satisfied with the care they and their compatriots receive at VA, they seem fearful that if they don't defend "our VA system" they will lose this system and ultimately the special veteran status and services that go with it. They seem to present an attitude of "it's not great...but it's ours". These veterans, who are generally the aging, pre-Vietnam era veterans, fear that any modifications of the system will make it worse or reduce services. They are concerned primarily with long term care.

What these veterans fail to realize, however, is that the demise of VA that they fear is precisely the outcome that will result if modifications <u>are not</u> made to VA's current delivery system. From our experience talking with those among our constituency who use VA health services, it seems that there are some very real concerns not with health outcomes as VA has traditionally defined quality, but with the customer service aspects of quality -- timeliness, proximity, courtesy, ease of access, amenities, etc.

While Vietnam-era veterans have often been labelled as radicals or rabble-rousers for their outspoken criticisms of the VA health care system, we are proud to note that this generation's forthright advocacy has elicited many improvements in VA services. It wasn't until the post-Vietnam era, for instance, that VA began to address the issues of Post Traumatic Stress Disorder and substance abuse, women veterans, environmental exposure, and general quality of care issues. If we are to preserve the VA health system's mission of serving this nation's veterans in a system of national health care reform, we must operate on the principle that "it's our system, let's make it work".

Veterans' Specific Concerns

Most veterans, along with the American population as a whole, are not terribly astute about health care services, delivery systems or choices. They seek care where they can conveniently access it, without really thinking about quality or customer service standards. When one is sick, these issues are not at the forefront unless he or she has a health care background, or unless significant deficiencies are noted. While this is not true of all VA facilities, most veterans who have utilized private sector health care providers can discern a lower customer service standard in the VA than in the private sector. There are a number of factors playing into this perception.

Veterans, like the American public as a whole, have expectations of having their illnesses improve regardless of where they access care -- VA or non-VA providers. Americans seem to trust their physicians and other health care providers to make them get healthy. Therefore this health outcomes aspect of quality isn't really relevant to the veteran's perception of VA health care.

The more important comparisons to make when evaluating VA's competitiveness with the private sector are the distinctly "customer service" aspects of timeliness, convenience, proximity/distance to home, staff politeness and courtesy, choice of providers, amenities, cleanliness, and cost. In each of these, except perhaps cost, VA is deficient. And these are the factors veterans will evaluate in choosing a VA or non-VA health care provider.

Current Customer Service Scenario

VVA has utilized the following scenario to explain the customer service standards VA fails to meet. Consider a veteran who is generally feeling o.k., but wants a physical examination. He has used VA services on occasion in the past, and he is service-connected disabled. He calls the nearest VAMC to schedule the appointment and for a long period is not able to get through because the line is busy. When he reaches the facility by long-distance phone call, he is put on hold for 10 to 15 minutes. He certainly doesn't want to hang up, for fear he won't get through again. Finally the appointment is scheduled for some six months in the future.

On the day of the veteran's appointment, he leaves home very early to travel the 150 to 200 miles to the VAMC by car or bus. When he arrives for his 10 a.m. appointment, he is forced to wait 4 to 6 hours to be seen by the medical personnel. At that point his is examined not by the same staff doctor, but by a different medical student or intern from the one seen at the last visit. This student runs the same battery of invasive diagnostic tests as were conducted on his last visit. There is no medical reason for these tests to be repeated, but they are useful for the training purposes of the student.

Let's presume that the exam detects a problem which will require surgery, such as a hernia. As a service-connected disabled veteran, he is eligible to get this treatment through VA. It is determined, however, that the hernia is not related to his service-connected condition. Therefore, because he is rated less than 50 percent disabled, he is not eligible to have the procedure done on an outpatient basis, as is the medically appropriate, cost-effective, private sector norm for this procedure. So he schedules the surgery on an inpatient basis -- again having to wait 6 to 8 months.

This veteran again travels the expansive distance back to the VAMC on the scheduled date of the surgery. When he arrives at the admissions desk he is "greeted" by a surly, disgruntled VA employee who treats him outright rudely. When he finally gets the lengthy paperwork processed, he is directed to his room. This is not a private or semi-private room, but rather a bay of 10 to 12 beds. He decides to call his family back at home to let them know he arrived safely -- but there is no phone. He wishes to pass the time while he's waiting for the surgery by watching television -- there is none.

Finally the procedure is successfully completed, and he is returned to his room to recover. He awakes from the anesthetic in a room full of other patients and their guests. He finds himself in a compromised position -- but there is no way to call a nurse.

Ultimately the medical outcome was successful. The outcome was perhaps exactly the same as a private sector experience. The difficulties he experienced along the way, however, would never be tolerated by private sector customer service standards. These are the areas VA needs to address in order to be competitive.

Veterans' Health Care Choices

When push comes to shove and veterans are given a choice of health care providers, its really very difficult to say who will do what. This will depend upon the local VA managers ability to establish networks of providers to bring care closer to the veteran population, the cost comparison and generally the VA's ability to erase its poor image by sprucing up its services, facilities and staff attitude. VA's ability to competitively survive health care reform will be determined at the local level, and its success will probably vary widely from service area to service area.

Some veterans who use VA service now will continue to do so, others will leave the system. This depends upon the individual's needs and the aforementioned ability of local VA managers to adapt to the changing environment. Those veterans requiring VA's special expertise in blind rehabilitation, prosthetics, spinal cord injury care, PTSD and/or substance abuse treatment, etc. will likely continue to use VA services. The general population, however, is frighteningly uncertain. Again, it depends upon the veterans perception of his or her local VA providers.

Likewise, the actions of veterans who have never used VA are very difficult to anticipate. Frankly, I think its more likely that these veterans will give VA a fair chance to win them as customers than those who have used the system previously and been disappointed. Current non-users may try using VA if the cost or other incentives are attractive. If, however, they discern significant deficiencies in customer service or quality, they won't remain VA customers for long.

Another very important aspect of health care choices that VA needs to consider is the fact that in most family units, it is the female that makes the health care decisions. VA will need to upgrade its sensitization to the gender-specific needs of females, both for women veterans and dependents of veterans. If VA is not prepared to provide comprehensive services to women and children either in-house or through arrangements with non-VA providers, it will not be competitive. VVA doesn't believe it makes a difference to veterans and their families if this care is provided within VA or through VA-arranged community-based providers; it must be provided and the quality and customer service must be comparable to the private sector.

The Future Role of VA Health Care

At this point in the game plan, its really difficult to predict whether more or less veterans will use the VA system when health care reform is implemented. We have seen the General Accounting Office (GAO) and Congressional Budget Office (CBO) estimates of future patient-load and are also familiar with VA's predictions of a bright future with high demand for services. VVA remains hesitant to grasp on to any specific prognostication, however, because the future of VA depends upon what the final reform package looks like, how VA fits into it, and how successful VA is at planning its strategy to bring itself up to private sector customer-service standards.

When deliberating about whether VA will look more like the private sector in a competitive environment, or if the current health care community will evolve into a VA-like system, I guess I would have to say that to a degree I think both will happen. VA must, if its going to survive, be a more customer-oriented system which networks to provide comprehensive care when and where the veteran health care consumer needs it provided. The private sector, however, will have to operate a more managed care delivery system, in order to operate in the most cost-effective manner possible; it is likely that for the first time the private sector will be forced to operate under a global budget.

The past history and present status of the VA illustrate what can happen to a large health care delivery system which is vulnerable to political pressure and public opinion. Regardless of the particular details of any programs adopted, the handwriting is on the wall. There must be emphasis on efficiency in delivery systems, cost effective utilization of allotted resources and quality health care as defined by the consumer. There is reason for grave concern when basic problems of cleanliness and privacy exist -- both for male and female VA consumers.

Many veterans, including Vietnam era veterans, see the VA as the only tangible sign of the government's regard or appreciation for their military service. These days, some veterans are given to an argument over the semantics as to the VA being an entitlement rather than a benefit or visa versa. I have

used VA services for eight years. In the clinics and hallways of VA Medical Centers, I have watched veterans young and old endure the experience of being "lost" in the largest and most expensive care system in the world. The politicization of illness and disability is neither a benefit nor an entitlement. Yet this is undeniably the essence of what a health care system managed by Congress has by it's very nature become.

Because VA is mandated by the quotas of the "Reinventing Government" recommendations to cut personnel levels, there is little hope the system will be as competitive as it needs to be in order to survive health care reform. Courtesy and timeliness are factors which really mean increased personnel and increased salaries to attract quality staff. Unless VA is given waivers to allow for an implementation of new approaches to providing care, competitiveness is only a watchword and not a realistic outcome.

The present missions assigned to VA need to be considered in the light of the health care reform changes. Real numbers of eligible veterans and present users of VA facilities, their locations and the nature and extent of their health care problems must be learned. The problems need to be defined before they can be solved. Reform means reassessing, realignment, repair, and reconstitution. I understand that VA is already attempting to assess its potential market and evaluate public relations approaches. This is exactly what needs to be done.

Although past plans for a national health care program have rarely included provisions for changes in the VA, there is no doubt that any effort to truly change the nation's health care delivery system must include this largest agency in the nation. Justification for maintaining VHA will need to be based in reality, not as a response to pork barrel politics.

Establishing Partnerships

Without question the issue of greatest importance in the veteran community is the future role of VA health care and the changes that will come as a result of the work on health care reform. How will the VA sustain it's relevance amidst the sweeping plans to guarantee quality health care for all Americans? While many in the veteran community fear the changes that might result from this evolution, the process promises to be one of opportunity rather than crisis. It is important to remember that the VA does not operate in a vacuum. In states, counties, and cities all over America there are programs and services that are rarely factored into any discussion of assistance to veterans.

State Homes, County Outreach Centers, State subsidies to disabled veterans, widows and orphans, funding for education, private industry apprenticeships for veterans and countless dollars and hours of volunteering from veterans service organizations are all actively reinforcing the present federal programs. How many of these services are duplicated or overlap? Is there active communication between agencies? It would seem that the task is to assess the real extent of these local and private programs and services, and to consolidate present resources in an effort to avoid duplication while ensuring that eligible veterans and their families receive a continuum of quality care.

One of the many lessons we learned in America's military mobilization for the Persian Gulf War was the importance of the VA as a backup for the Department of Defense. As a Retired Air Force Nurse, who cared for casualties during the Vietnam war, I seriously questioned if the VA had the resources to adequately handle the kinds and numbers of injuries that were originally projected to occur if the land war became protracted. Perhaps the interface with military health care systems will remain an essential part of the VA mission. It is important to remember that such a vital role needs to be supported with adequate funding, planning and training of personnel and that this auxiliary system be in a constant state of readiness. In a new era of health care, there is immense potential for an integrated federal health care system which would capitalize on the strengths of the US Public Health Service, Department of Defense and Department of Veterans Affairs to provide quality health care for active duty military members, veterans and their families.

Regardless of the shape national health care takes, there remains a great need to ensure that veterans who use the VA receive timely, courteous, quality care. While the VA can demonstrate that per capita costs for care are less than for care in the private sector, one has to question what we are talking about in regard to care? The VA needs to focus on quality as more than an outcome and more than utilization as the benchmark for measuring value in their delivery systems.

Quality care is in the eyes of the users. Veterans know where to go and who to see to get the best care. They travel miles in a bus across Texas to a substance abuse program because the nurse there really takes care of you if you are serious about your problem. They come from the backwoods of Maine and Vermont to West Haven to see two doctors there who really care. The opportunity of the future VA is

to focus on the services VA does best. Post Traumatic Stress Disorder, Prosthetics, Spinal Cord Injuries, Blind Rehabilitation, Homelessness, Seizures, Geriatrics are only a sample of the care VA does better than anyone. Other services can be arranged or complimented by developing a network of preferred providers, contracting reciprocal agreements with medical schools, increased utilization of Clinical Nurse Specialists, Nurse Practitioners, Physicians Assistants and Mobile Health Care Clinics.

Because consumers of VA health care have rarely been purchasers of that care, the sense of accountability to the customer-consumer-veteran has never by felt by VA. In each of the VAMC's I visited, I suggested that an Advisory Committee be formed to give veterans an opportunity to have input in the process, a forum to raise questions and defuse misinformation, as well as working with the hospital administration to improve conditions. As these committees have begun their work, there has been a reluctance in some places to share even this small amount of "power". However I am also happy to say in others like the West Haven VAMC, we have truly developed a partnership which has strengthened the consumer-provider relationship and promises to be a new resource for improved conditions at the hospital.

The West Haven VAMC was under siege for suicide deaths near and in the facility. Perhaps the legacy of those scandals is the strong ties we developed and the common-sense attitude of state and federal officials to get the job done. The VAMC's and our VIP program at the State Hospital, as well as providers in the private sector, and Veteran Service Organizations now work together to ensure homeless and disabled veterans have a continuum of care that gets results. I believe this is a cost effective model for the future care of veterans.

In order to competitively attract veteran customers, VA needs to develop a two way communication with its constituencies; local veteran clients who wait endless hours for late doctors and missing medications may have some ideas on how to improve their VAMC. Also, it is imperative that VA begin working with the local community to establish provider networks for the provision of comprehensive care.

Conclusion

Competition will depend on the playing field -- the health care options to all citizens in the new scenario versus what specialties VA can offer. Since VA does little dental care now it is ludicrous to believe they will develop an adequate in-house service in the near future. Right now a VA fee-for-service card is more valuable than a pre-paid Gold MasterCard, thus it seems those dependent on VA want other options. When GAO and CBO make these predictions of patient loss, they are describing the death knell to VA health care facilities. One of the biggest criticisms of health care reform is that everything will be like the VA -- all Americans will be subject to rationing and dehumanizing experiences.

What VA has to do is work in individual communities to develop the maximum utilization of resources on the state and local levels. Every town doesn't need open heart surgery in every hospital. However the needs of veterans can be projected into the planning for VA policies and services now. Just saying VA will be competitive doesn't make it so.

The real future of the VA cannot be written by bureaucrats who see this as the only way to keep a job until they can retire. The future must be written by creative, grassroots networking to assure VAMCs on each location have developed their own plan of action. Most importantly this is a time of great opportunity for change and progress. VVA is committed to the preservation of the VA as a health care provider for veterans, but VA leaders, managers in the field, and general personnel must understand that to survive VA must systemically evolve to a more responsive health care provider than it is today. We intend to do all in our power to support this systemic evolution.

Mr. Chairman, this concludes our statement.

STATEMENT OF
DAVID W. GORMAN
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
APRIL 20, 1994

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 1.4 million members of the Disabled American Veterans (DAV), and its Women's Auxiliary, I want you to know how very much we appreciate the opportunity to relate the views of the DAV concerning the Department of Veterans Affairs (VA) health care system. Particularly, our testimony was solicited regarding veterans' perceptions of VA, their opinions about the role of VA in a reformed health care system and other related issues.

Mr. Chairman, the principle focus of today's hearing has, in our view, been discussed in great detail over the years in various hearings conducted by this Subcommittee, the Subcommittee on Hospitals and Health Care, the full Committee, as well as the Senate Veterans' Affairs Committee. Certainly, the questions posed in your March 21, 1994 letter of invitation are not only pertinent ones, but critical to not only the future of VA, but to VA's very survivability in a reformed health care delivery system in this country.

In order to provide the Subcommittee with as credible testimony as possible, we have chosen to formulate our views around a health care survey conducted by the Department of Maryland, Disabled American Veterans, during the latter part of 1993. (A copy of the completed survey and veterans' responses has been submitted for the record.)

Mr. Chairman, I would state at the outset that the survey was devised and conducted for the sole purpose of determining DAV members' views relating to the VA's health care system. There was no specific attempt to bias the responses in any particular fashion. Nor was there a specific goal of gathering data to support or oppose any particular position or opinion.

Mr. Chairman, the DAV health care survey was contained in the Department of Maryland's DAV Newspaper provided to some 17,000 DAV members in the state of Maryland. The results of the survey presented in our testimony are derived from tabulating 206 completed surveys. Admittedly, the rate of response was small, however, we believe the findings are representative of DAV members' views and, therefore, can be easily extrapolated if desired.

Mr. Chairman, the highlights of our survey included the finding that of the veterans responding, 41 percent were World War II veterans, 24 percent were Korean veterans, 24 percent were Vietnam veterans, 5 percent were post Vietnam veterans and 5 percent were pre-World War II veterans.

Of the veterans responding, 12 percent were adjudicated by VA as 100 percent service-connected disabled veterans, 14 percent were rated between 50 and 90 percent disabled, 23 percent were rated between 30 and 50 percent disabled and 33 percent were evaluated less than 30 percent disabled. Also,

15 percent of the respondents had an unknown disability evaluation. It is important to note that all respondents are service-connected disabled veterans.

Of the responding veterans, 32 percent were employed in a job that provided health care benefits while 63 percent were not. Conversely, 62 percent of the veterans were eligible for and enrolled in Medicare. Therefore, virtually all responding veterans have some degree of health care insurance coverage.

Concerning the broad issue of health care reform, specifically the reform proposal as advanced by the President, 44 percent knew something about the President's health care plan while 32 percent did not know much, 15 percent knew a lot about the plan, and 1 percent admitted to knowing nothing of the President's plan. The corollary question regarding the belief that reform would be good for the nation's overall health care system, showed 27 percent of the veterans thought the President's plan would be beneficial while a like amount, 27 percent, felt the plan would be worse; 17 percent felt no change would ensue, 15 percent felt the President's plan would be bad while 7 percent felt the plan would be much better and 7 percent did not answer the question.

With the knowledge veterans did have of a new health care system, 44 percent thought care for veterans would remain about the same, while 41 percent believed worse care would occur and 10 percent opined that veterans would receive better care in a reformed system.

Mr. Chairman, 59 percent of survey respondents report previous treatment by VA while 25 percent had not received VA care with an unknown factor of previous treatment at VA being 16 percent. Veterans overall opinion of the VA medical care system showed 39 percent of veterans feeling the system was good, 24 percent rated the system poor, 12 percent compared the VA equally to the private medical community, 7 percent of respondents felt the system was excellent and 5 percent felt it to be bad.

When asked to consider the aging veterans' population and whether VA should admit veterans without service-connected disabilities, 64 percent of respondents felt VA should admit nonservice-connected veterans while 30 percent felt they should not and 6 percent offering no answer. Of particular note, was the fact that 62 percent of responding veterans felt VA should treat dependents of service-connected disabled veterans while 32 percent felt VA should not treat dependents and 6 percent not answering. It appears that respondents to the survey drew a clear distinction between dependents of service-connected veterans and "non-veterans" as a full, 90 percent of respondents answered no to the question of whether the VA should admit non-veterans to VA medical facilities with only 5 percent feeling they should and 5 percent not answering.

Mr. Chairman, veterans were asked if they could receive all of their medical treatment and medication through VA for no cost and not pay for health care insurance or pay the same health care insurance rate and deductibles as everyone else for the National Health Care Plan for private care. A full 45 percent of veterans responding said they would choose the VA system for their health care needs while 29 percent would choose the private sector for care with 23 percent being undecided. A follow-up question asked that if VA provided evening and weekend hours or appointments, would you select VA as your health care provider, 60 percent said no, however, with the availability of such services, 40 percent of respondents who otherwise would not select VA answered yes.

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Finally, veterans were asked if there was not a VA facility close by and the VA were to put an outpatient clinic within 25 miles of their home, would they select VA; 32 percent said no, 20 percent would select VA, 12 percent did not respond and, 36 percent of the respondents reported having a VA facility within 25 miles.

Mr. Chairman, the information derived from the Department of Maryland's health care survey is, in our view, highly significant and informative as to veterans' overall opinions concerning not only health care reform but, specifically, the continued existence of and a need for reform of the VA health care delivery system.

Clearly, like most Americans, veterans admittedly are not well informed or educated concerning the details and complexities of a proposal to reform this nation's health care system. However, veterans clearly recognize and acknowledge the need to reform VA. The majority of responding veterans have used or currently use the VA for their health care and their overall opinion of the system is favorable. Also evident is the fact that 90 percent plus of the responding veterans have clear choices and options of where they currently receive their health care as they have some form of health care coverage either through Medicare and/or private health insurance.

Importantly, DAV members do not feel the system should or could be limited to treating only service-connected disabled veterans. Rather, by a clear majority, DAV members favor not only the position of treating nonservice-connected veterans but also feel the VA should treat dependents of service-connected disabled veterans. Not surprisingly, 90 percent of DAV members feel non-veterans should not be treated at VA medical facilities.

Mr. Chairman, one of the more telling conclusions reached from the survey was the hypothetical situation of veterans being able to utilize VA for no out-of-pocket expenses or the same out-of-pocket expenses as all other citizens under a national health care plan. Not surprising to the DAV was the fact that 45 percent of the respondees would choose the VA system for their needed care. With access more attainable, 40 percent of veterans who would not normally choose VA would also opt for VA care.

Mr. Chairman, clearly our membership in the state of Maryland feels the VA is a system that needs to be maintained as an independent health care delivery system primarily for the treatment of disabled veterans and, when indicated and feasible, the treatment of dependents of service-connected veterans. Also, our membership believes the VA to be a system providing needed services to a deserving group of individuals in a quality manner. Given choices, significant numbers of DAV members choose and will continue to choose the VA as their provider of health care services.

We believe the results of the Department of Maryland's health care survey are generally indicative of the overall veterans' population. Of course, depending on many, many factors, information could be gathered from veterans representing either end of the spectrum. We believe data could reasonably be collected from veterans who would do nothing but sing the praises of the VA health care delivery system. Conversely, we believe selective data could be gathered that would damn the system as one of bureaucratic entanglement and lacking any compassion or quality medical care. Certainly, we do not subscribe to either view but choose to believe veterans' perceptions lie somewhere in the middle but, and as suggested by data, leaning more toward a positive view of the VA.

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Mr. Chairman, again we appreciate the opportunity to share our views and are prepared to respond to the Subcommittees questions.

ELWOOD J. HEADLEY, M.D. ACTING DEPUTY
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
APRIL 20, 1994

Mr. Chairman and Members of the Committee,

Thank you for this opportunity to discuss with you today veterans perceptions of VA health care as we are planning to move into a new era under health care reform. Planning is now underway to make the profound changes in the VA health care system that are necessary for us to succeed in a new competitive environment. While we await these changes we are encouraged by a recently released article entitled "Patient Satisfaction in VA Medical Centers and Private Sector Hospitals: A Comparison." It compares veteran's perceptions of inpatient care at VA medical centers with that of patients in the private sector. On the twelve parameters measured, VA patients were as satisfied as those in the private sector with their care, including that from direct care providers--physicians, nurses and social workers.

The President's proposed Health Security Act, H.R. 3600, includes provisions for veterans and their families to have a choice in health care, and we want the VA to be the best choice available. To do this the VA must

offer to veterans the best value in terms of readily accessible quality care, delivered with courtesy and respect. It is not enough that VA simply maintain the customers we now serve. While it is important that we retain current customers, we must appeal to those veterans who either do not currently look to the VA as their health care provider of choice or who, because of our complex eligibility rules, cannot gain access to VA.

In the new competitive environment, veterans' perceptions of VA will be critical to the success of the VA health care system. We will take our lead from what veterans tell us they want and need from a health care delivery system. First and foremost, VA health care reform will make health care readily accessible to veterans and their families. We will correct scheduling and assignment problems in our outpatient clinics as identified by GAO to end the long waits and delays that have plagued our health care delivery in the past. VA's health care proposal includes plans for providing more local care through sharing agreements and other means than in the past. Our goal is to make health care as readily accessible to VA health plan enrollees living in remote areas as possible.

In response to the President's provisions for VA in the proposed Health Security Act, H.R. 3600, the Secretary began planning for VA's health care reform in October of 1993 and the VA Health Care Reform Program office was formed. Then, we brought together literally hundreds of VA Central Office and Field staff, representatives of our affiliated medical schools, veterans service organizations and others to address the task at hand--designing health care reform for VA. We saw this as perhaps the greatest opportunity since the VA began to bring about needed system

wide restructuring, making VA healthcare delivery more responsive to the needs of the veterans it serves.

When we began planning for VA's health care reform last year we did so, mindful of a General Accounting Office (GAO) study that was done in 1987 indicating that, given a choice, nearly half of the veterans who now use VA would go to a non-VA provider. In addition a recent Congressional Budget Office (CBO) report, which is based on no data other than the GAO study, suggests that as many as 25 percent of veterans now using VA as their health care provider would go elsewhere, if given a choice. Though the GAO Report is dated and does not take into account the improvements in VA health care that H.R. 3600 would make possible, , it was nonetheless troubling to us as we set about devising a health care reform plan that could enable VA to survive and succeed in a competitive marketplace. In addition, the CBO report was thought-provoking in this regard.

In light of this data it was important to determine whether the GAO report was a currently valid assessment of veterans' perceptions in selecting their health care provider. We needed to know whether perceptions were improving, worsening or remaining the same in relation to choosing VA health care when given a choice. A recently completed VA national study supplies up-to-date statistics that indicate a more favorable response than the GAO study of 1987 and yet indicates that much work must be done to attract the numbers of enrollees that are needed for a successful VA health plan. This recently compiled data focused on veterans' perceptions of VA health care and the likelihood of veterans enrolling in a future VA health plan. In this study, approximately 1500 veterans from across the country

participated in ten-minute structured telephone interviews. The three categories of veterans surveyed included current users, previous users and non-users. Significantly, these findings indicated that 67 percent of current users would be favorably disposed toward enrolling in a VA health plan if given a choice between VA and a private health plan. The survey also indicated that 47 percent of former users surveyed and 27 percent of non-users surveyed would consider enrolling in a VA health plan. These statistics are more encouraging than the GAO findings which indicated that nearly half of those currently using VA health care would leave if given a choice. Another interesting finding from the survey is that the reason stated most often by veterans for choosing a VA health plan over competing plans is "good service," quality care," and "happy with VA care." Specifically, 67 percent of current users, 72 percent of former users, and 39 percent of non-users took this position.

We have learned from this survey is that veterans who are recent users of VA health services are more favorably disposed toward joining a VA health plan than are former users or non-users. This trend offers insight into VA's market potential. There are 2.5 million current users, 2.5 million former users, and an impressive 22 million non-users. Similar positive data has come forth from a recently completed study, using a newly developed patient feedback survey instrument. Using this instrument, also known as a "customer feedback loop," for initial pilot testing among 7700 veterans, reveals that 82 percent of the respondees were "somewhat" to "completely" satisfied with the VA care they had received.

Though the findings from this recent study are considerably more

favorable than the GAO study of 1987, we have a long way to go in marketing to those 22 million non-users and 2.5 million former users. Our challenge is to not only restructure a VA health care system under health care reform that is receptive to customers needs but to market this system in such a way that these non-users and former-users are convinced that VA's health care plan offers the best value for them and their families.

To become a successful competitor in health care reform, VA must have a means for reaching its potential customers. Therefore, prior to the actual onset of reform VA plans to conduct highly visible marketing and advertising campaigns to compete with the aggressive advertising of other providers. This will help give VA a competitive advantage in gaining a market share of customers, thereby enhancing VA's ability to begin health care reform with a sound customer base.

Our high visibility as the largest health care provider in the nation, makes it all the more urgent that VA should take the lead in setting the standard for the nation. We should accept nothing less.

Our challenge is to reach the 53 percent of former users who did not indicate that they would enroll in a VA health plan and the even larger challenge of reaching the 73 percent of veterans who have never used the VA and who also indicate a disinclination to do so. It is important that all potential enrollees are made aware of the consistently high quality of VA health care. Not only are all VA medical centers accredited by the Joint Commission on Accreditation of Healthcare Organizations--they consistently receive scores that are considerably above the national average

for the private sector. Additionally, results from the newly implemented External Peer Review process indicate that VA care meets or exceeds standards 96 percent of the time. This speaks well to the quality we are delivering. Under health care reform we will restructure our quality assurance methods accordingly, to meet the changing environment of the new system. VA's internal report required by Public Law 99-166 showed VA's surgical care to be identical to that of the private sector in terms of quality. Furthermore, a recent I.G. report comparing VA care to university hospitals showed identical quality of care. Our challenge is to ensure that every veteran is aware that under health care reform they have a choice in selecting a health care plan and that VA's health plan will be their best choice. We accept this challenge eagerly and determinedly.

That VA takes its charge seriously in seeking to provide the highest quality care is not new. VA is a recognized leader in both research and education. Multi-center VA cooperative studies are continuously in progress, making certain that the very latest developments are available to our veterans. VA is affiliated with major research and academic institutions, making available to our veterans the expertise of world renowned scientists, physicians and others to assure the best available health care. With VA health care reform, this tradition will continue.

As a result of quality of care problems at a few VA medical centers a negative perception persists that plagues the entire system. Nevertheless, we still need to address the negative perceptions and replace them with a positive recognition.

To assure that we are more attuned to what is actually important to our veteran patients VA is changing the assessment tool used for measuring customer satisfaction. In its place, we plan to implement a "customer feedback loop" type of survey that will measure seven identified priorities (standards) of quality:

- Respect for Patient Preferences
- Emotional Support
- Continuity of Care and Transition to the Community
- Patient Education
- Family Participation
- Communication with the Patient
- Physical Comfort, Including Pain Management

VA was actually the industry leader in 1974 when we instituted the first known patient satisfaction surveys. This was done in response to the recognized need for a system-wide method for determining how satisfied patients were with the care and services they were receiving. Over the years the results of these surveys have been consistently positive, showing high levels of satisfaction by veterans with the care they have received, both as inpatients and as outpatients.

Though the customer satisfaction instrument was changed several times since 1974, a recognized problem with each of these surveys was that the information available had not demonstrated opportunities for improvement. As early as 1992, the VA Office of Quality Management initiated a process to replace the current patient satisfaction surveys. Instead, a "customer feedback loop" survey instrument was selected as a possible improvement

in supplying information from patients that would not only measure our patient's level of satisfaction but would also allow identification of areas of special concern or special needs. After careful evaluation this instrument was found to supply the information needed from patients in a much more useful form than had previously been available.

Therefore, after pilot testing of this instrument is completed later this year it will be placed into use on a regular basis at all VA health care facilities to monitor customer's satisfaction with their care. The information derived from these surveys will help us in adjusting our programs and our care delivery to respond to the needs of our customers. An adaptation of this survey instrument is in use in the private sector, which, for the first time, allows comparisons between VHA and the private sector. The new competitive marketplace of health care reform more than ever demands that we derive the direction of our services and the care we provide from what our customers tell us is important to them. Use of this "customer feedback loop" provides this information. Equally important, we need to know how our plan compares with other plans available in the community. The "customer feedback loop" supplies this information as well. We think that use of this instrument will be extremely useful in helping us respond sensitively to providing customer service and in determining how VA care measures up with other providers. Under the competitive environment of health care reform, the VA will be conducting business in much the way it is done in the private sector. We will benefit from incorporating into our operating strategies the following principles upon which the "Customer Feedback System" is based:

- Standards of quality are first negotiated between the customer and supplier such that customer needs and expectations can be met while meeting supplier responsibilities.
- Meeting these standards of quality satisfies the customer.
- Satisfaction predicts customer loyalty.

Thus, the "customer feedback loop" survey is a more valid and reliable instrument than those previously used, allowing us to increase customer satisfaction by knowing what is important to our patients as well as how well we are meeting their expectations. In addition, we look forward to implementing this instrument as a means to help us get in step in the new competitive marketplace of health care reform. We believe the competition is healthy in promoting increased sensitivity to veterans' needs. The private sector, our competitors, who will also be competing for veteran enrollees and their families will help to keep us on our toes and will, at least partially, be the impetus for our becoming not just the largest but by far the best health care provider in the nation.

Mr. Chairman, VA is at a crossroads. The Department of Veterans Affairs is preparing to become a successful participant in the national health care delivery system in response to the President's proposed Health Security Act and as we do so, we will keep the promise to our veterans. We look forward to this as an opportunity to restructure the VA health delivery system and greatly improve service to the nation's veterans. The full range of prevention, treatment and wellness services, strengthened by VA's research and education mission, make up VA's health care reform plan and puts VA in an excellent position to become a successful participant in the national health care delivery system.

This concludes my formal statement Mr. Chairman. I and my colleagues will be pleased to answer any questions you or other members of the Committee may have.

Non Commissioned Officers Association of the United States of America

225 N. Washington Street • Alexandria, Virginia 22314 • Telephone (703) 549-0311

STATEMENT OF

LARRY D. RHEA

DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS

TO THE

HOUSE VETERANS AFFAIRS SUBCOMMITTEE

ON

OVERSIGHT AND INVESTIGATION

REGARDING

VETERANS' PERCEPTION AND PARTICIPATION IN HEALTHCARE REFORM

APRIL 20, 1994

Chartered by the United States Congress

Mr. Chairman, The Non Commissioned Officers Association of the USA (NCOA) appreciates the opportunity to comment on the perceptions of veterans and their likelihood for participation in a reformed veterans health care delivery system. The comments expressed herein represent the views of the Association's 160,000 members.

The series of questions that you presented in your March 21, 1994, letter of invitation are clearly relevant to the subject of VA health care reform. Although vitally important, NCOA must acknowledge that answers to your questions are, at this point, highly subjective since little or no hard data exists upon which to base an objective opinion. Therefore, NCOA's comments in this statement are conditioned by our experience as a Veterans Service Organization and on anecdotal information and cases.

Prior to addressing each specific question that you posed, NCOA wants to express it's deep and abiding appreciation for the judicious attention that the distinguished Chairman has given to VA health care. Over the course of several years and numerous hearings, Mr. Chairman, you have examined virtually every aspect of veteran health care and the problems attendant with the timeliness and efficiency in delivering quality care to veterans. The common thread throughout has been a mutually shared belief that veterans have earned and should receive care and service that is second to none. For your past efforts and this hearing today, NCOA is grateful.

A BEGINNING COMMENT

The advent of national health care reform has focused considerable attention and urgency on reforming VA health care in anticipation of a nationally competitive system. In the view of many veterans and certainly in the view of NCOA, change is in order for VA. NCOA, along with other Veteran Service Organizations, has been advocating for many years that change must occur to permit VA to consistently provide the quality care that veterans deserve. The introduction of national health care reform now places even more importance on improving the VA system. The opportunity also represents an enormous challenge. Many veterans believe that if VA does not meet the challenge that they could very well witness the demise of the VA

system. Whatever the outcome of the national health care debate, it has at least served the useful purpose of mobilizing and focusing the entire Veterans Health Administration.

The outcome of national health care reform remains very much in question. Yet, just about everything that has been considered or planned has been laid out in the context of the VA competing in a yet to be decided national system. NCOA is disturbed by the proposition being espoused by many that the only way to enact VA reform is through some sort of all encompassing larger national plan.

NCOA clearly recognizes that VA and veterans will be impacted by national health care reform that will probably be linked to VA and involve choices. However, the Association does not share completely the contention that the only way to get VA reform is through a broader national plan. The Nation already has an obligation to veterans. With or without national health care reform, NCOA believes that many changes to improve the VA system can and should be pursued independently. NCOA believes this is fundamental to permit the VA to be a quality choice that would attract the number of veterans on which the future survival of VA will hinge. It would be tragic if the VA changes that are needed now became entangled in and were contingent upon the passage of broader national health care legislation.

WHAT DO VETERANS THINK ABOUT VA HEALTH CARE?
HOW DO VETERANS COMPARE VA HEALTH CARE
TO THAT IN THE COMMUNITY?

The answer to these questions will vary with each veteran and will be shaped by different geographical areas and regions. For some veterans, the answer will be that many features of the VA system are equal to or better than that in their surrounding community.

In all likelihood, veterans who respond in this manner are located in an area that provides access to a well-run, effectively managed VA facility. Positive responses will be gathered from veterans who have not had to endure long waits, denied access or experienced the frustration of archaic eligibility rules and rude, uncaring employees.

On the other hand, far to many veterans will respond in a negative manner because they have been repeatedly confronted with a less than satisfactory experience that is exactly opposite to that described above. Veterans with a negative experience have a negative view. Unfortunately, this occurs all too frequently when one considers that VHA's existence is for the exclusive purpose of serving veterans.

There are several views that are universally held by veterans regardless of whether their experience has been positive or negative. Included among these are the following:

> VHA belongs to veterans.

> The system was created for veterans and exists to serve veterans.

> Veterans generally take pride in their status as veterans.

> Veterans feel betrayed and forgotten.

DO VETERANS BELIEVE THAT VA HEALTH CARE IS BETTER, ABOUT THE SAME, OR NOT AS GOOD IN TERMS OF QUALITY, CONVENIENCE, CHOICE OF PROVIDERS, AMENITIES, STAFF POLITENESS AND COURTESY, CLEANLINESS, COST, PROXIMITY/DISTANCE TO HOME, TIMELINESS OF DELIVERY, AND OTHER LIKE FACTORS?

It is accurate to say that those veterans who are able to get care in the VA system are reasonably well-satisfied with the technical quality of the care received. It is widely recognized that the VA has been a world leader in many of the medical disciplines (i.e., head injuries, spinal cord, prothesis, etc.). However, the quality of care is not the primary question. The underlying question, and hence the challenge in health care reform, is who can receive care? For many veterans, even those with service connected disabilities, the door is now essentially closed. Eligibility reform must occur with or without national health care reform.

The remaining factors of the above question get to the crux of whether or not veterans will choose a reformed VA system. It should come as no surprise that convenience, amenities,

simple courtesies, proximity and timeliness of delivery do not rate high among many veterans. In NCOA's experience, veterans generally view these factors as well below community standards. Granted some veterans have a favorable impression of VA and would rank their care and other factors as equal to that in their community. NCOA suggests that the response of veterans to this question will be directly related to the quality of the management and attitude of staff members at local VA facilities.

In NCOA's opinion, how veterans perceive their system is crucial and, regardless of the actual quality of technical care, may well be the major impediment. A concerted effort must be undertaken to address factors such as amenities, convenience, cleanliness, timeliness, etc., if the VA has any hopes of surviving in a competitive environment. The perception among veterans must be enhanced.

HOW WILL VETERANS RESPOND TO HEALTH CARE PROVIDER CHOICES EXPECTED TO BE BROUGHT ABOUT BY REFORM?

Although subjective, the question of choice is important. It is very difficult to predict human behavior but individuals will usually do what is best for their own personal situation. Veterans who have guaranteed alternatives other than VA, and if the factors in the preceding question are viewed more favorably, NCOA suggests that veterans in all likelihood will choose alternative care.

WILL VETERANS WHO NOW USE VA HEALTH CARE CONTINUE TO DO SO OR GO ELSEWHERE FOR THEIR CARE?

It is fairly obvious that a large percentage of those seeking or receiving VA care now do so because of the current cost advantage VA offers. Under national health care reform, broader choices and access to the national health care establishment apparently will be available. How this will affect VA is difficult to predict even for mandatory category and low income veterans who currently comprise the majority of VA's patients.

NCOA postulates that some mandatory category veterans will continue with VA particularly if the care is in an discipline of which the VA is clearly recognized as a leader (i.e., head injuries, spinal cord, etc.). How many such mandatory category veterans would make such a choice is impossible to ascertain.

Under the Administration's proposal for national health care reform, apparently all low income and indigent citizens will be provided health care either free or subsidized in some manner. For these individuals, NCOA suggests that their veterans status will become a relative mundane point. If these individuals can receive the same or better care in their local community, NCOA believes that their decision of choice will be governed by such factors as convenience, access, etc., and their status as a veteran will have little bearing on their decision.

WILL VETERANS WHO DON'T USE VA NOW, BEGIN TO?

Less than 3% (79,000 of 2.99 million) of the applications for VA care in 1993 originated with discretionary category veterans. This suggests one of two things. Either discretionary category veterans will not choose VA or the vast majority of veterans who receive care from non-VA sources is a factor of restrictive eligibility rules. NCOA suggests that eligibility rules are a major contributing factor and should clearly signal the need for eligibility reform.

The future of the VA system will hinge on attracting as many veterans as possible. The VA system must be perceived as, and in fact be, something more than a system of last or only resort. Eligibility reform is not the sole answer. Eligibility reform must be accompanied with the perceptual changes addressed earlier.

WHAT OPTIONS WILL VETERANS HAVE FOR DEPENDENT HEALTH CARE AND HOW DO VETERANS COMPARE VA PROVIDED AND COMMUNITY BASED DEPENDENT CARE?

Few dependents currently receive care from VA. Unquestionably though, spouses exert great influence in the family's selection of a health care provider. A VA plan designed to accommodate spouses and family members would increase the likelihood of selecting VA, although to what extent is highly speculative.

NCOA is inclined to believe that veterans view community based dependent care more favorably than VA dependent care. The vast majority of the Nation's veterans are male. Only recently have large numbers of females acquired veteran status. Only recently has the VA, with the urging of the Congress, started to focus and expand women veteran's health care and service. Thus, NCOA believes that VA must become recognized as a leader in health care for women if families are ever going to be persuaded to choose VA as their provider.

WILL VA HEALTH CARE BECOME MORE LIKE HEALTH CARE AVAILABLE IN THE COMMUNITY OR WILL HEALTH CARE IN THE COMMUNITY BECOME MORE LIKE VA?

NCOA believes it is likely that both will more closely resemble each other but not necessarily in either of their current images. Clearly, VA must become more like the community based system in terms of proximity, cleanliness, amenities, and timeliness. On the other hand, the community based system must become more like the VA system in terms of cost containment. It is not at all unlikely in post-health care reform that the difference between VA and community health care would be very little.

WILL NEARLY HALF OF THE VETERANS WHO NOW USE VA GO TO A NON-VA PROVIDER AS REPORTED BY GAO? WILL AS MANY AS 25% OF THE VETERANS NOW USING VA GO ELSEWHERE AS REPORTED BY CBO? WILL MORE VETERANS COME TO VA AS SOME VA FACILITIES HAVE PREDICTED?

Aside from the General Accounting Office and Congressional Budget Office reports, little hard data exists upon which to base a response. The projections of these two reports vary significantly but both indicate that a sizeable percentage of veterans will choose a non-VA provider. In stark contrast to the GAO and CBO reports is the opposite prediction by VA that more veterans will choose VA as their health care provider.

Interestingly, current VA predictions under national health care reform conflict with an earlier DVA statistical brief by the Assistant Secretary for Policy and Planning published in September 1993 entitled "Implications of Universal Health Coverage: Some Lessons From Medicare."

The statistical brief addressed the very question that the Chairman is asking today. What will happen to demand for VA hospital care if and when there is universal coverage where everyone is guaranteed access to some level of health care? Will veterans who currently use the VA health care system change their choices of health care preference once they have a guaranteed alternative?

Included among the findings of the statistical brief were the following:

> The main reason for non service-connected veterans going to VA for medical care is economic.

> Eight-one percent of non-service connected veterans qualifying for VA health care are low income (i.e., meet the means test criteria).

> Upon reaching age 65, when veterans have a guaranteed alternative, about 12 percent who would have come to VA do not; similarly, about 8 percent of outpatients do not come back.

> The exodus from VA at age 65 appears to be getting greater.

NCOA would caution against drawing broad general conclusions from the statistical brief and to consider it findings in context. NCOA does believe though that the findings are revealing and possibly an indicator of what will happen when veterans are given an alternative that also guarantees health care. These findings deal only with Medicare as a guaranteed alternative.

What the impact will be on the VA for the pre-age 65 veteran who is guaranteed alternative care under national reform is open to speculation.

CONCLUSION

There are some things that we do know. Among these are that some veterans today want to use the VA and are denied while others who can don't. Some veterans are very satisfied with the VA while far too many are completely frustrated with the entire system. Substantial amounts of the Nation's treasure have been invested in the current VA system. It's problems aside, the specialized needs of many veterans are being met by the VA that otherwise would go unattended.

It is apparent that the national health care scene will change. But more apparent in the minds of veterans is that their system, which was created for them and exists to provide for their care, must also change. As NCOA has previously stated, irrespective of national health care reform, the task of reforming the VA system should be undertaken with dispatch. Eligibility reform must occur. The negative perception of VA held by many veterans must be reversed. The devastation to be imposed on veteran health care as contained in the Fiscal 1995 budget cannot be allowed to occur.

The proponents of H.R. 3600, the Administrations National Health Security Act, argue that the President's plan is the only plan in town the addresses the VA. While accurate to a degree, it is more than a little misleading. NCOA is gravely concerned about the future of VA health care under H.R. 3600.

The future viability and existence of the VA system under the President's plan, relies solely on the number of veterans who will choose VA as their health care provider. The number of veterans required to choose VA under H.R. 3600 to ensure the systems survival is not stipulated; Moreover, there is sufficient historical trends to believe that, at any future point in time and for a multitude of reasons, it could be declared that VA is "not competitive" and a move undertaken to change or dismantle the system. However, NCOA has, a more fundamental and overriding concern with the President's plan.

H.R. 3600 is a complete abrogation of a VA system that is supposed to exist on the basis of its obligation to serve disabled veterans. Irrespective of the number of veterans who may or may not choose a reformed VA health system, the future of the VA system must be uncompromisingly predicated on its ability to fully serve the disabled veterans. That is the Nation's obligations. It must not be forsaken.

Thank you.

AMVETS Response to Additional Questions
Regarding Veterans Perceptions of VA Healthcare
Submitted by the Honorable Lane Evans

1. Question: What customer service standards should VA establish for veterans healthcare?

   Answer:
   a. timely access to appointments - no more than a 30 day wait (AMVETS national resolution)
   b. being seen on time
   c. convenient locations
   d. gender-related amenities and privacy
   e. equal or exceed local community standards

2. Question: What VA services are not consistently first class today?

   Answer: Items 1a through d are continuing problems.

   Question: What are veterans priorities for improving VA services?

   Answer: ELIGIBILITY REFORM, then

   a. what you can be treated for
   b. how soon you get treated
   c. conditions under which you are treated

3. Question: What improvements should VA make in the patient representative program?

   Answer: The patient representative must have direct access to the chief of staff and facility director.

4. Question: Should VA care only be for veterans and their dependents?

   Answer: VA's primary focus should remain veterans and their dependents. If and when there is excess capacity, AMVETS continues to support sharing and contractual arrangements that ultimately benefit VA's primary patient base.

Question: Please comment on the importance of physician choice for veterans and Va plan enrollees.

Answer: Choice is important, of course. But not as important as convenient community-based facilities (which will often take care of the choice issue). While it is preferable to see the same doctor when possible, it is more important that VA provide a full continuum of care in surroundings that encourage people to enroll.

RESPONSES OF DAVID W. GORMAN
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
TO THE QUESTIONS OF
THE HONORABLE LANE EVANS
CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OF THE
HOUSE VETERANS AFFAIRS COMMITTEE
Hearing on April 20, 1994

Question 1: What customer service standards should VA establish for veterans' health care?

Answer: Clearly, in the upcoming era of health care reform, the VA must take huge strides forward in the area of customer relations. The issue of continuing to provide a high level of quality patient care must remain first and foremost. After that, VA must, in our view, concentrate on basic fundamental principles such as timeliness of care, access to health care services through expanded points of contact, adequate clinical space, flexibility in the hours of operation of VA medical facilities, and involvement of the patients and family in the medical care treatment plan. The broad issue of employee sensitivity to patients' needs must be addressed by VA in a proactive way. It is a safe statement to make that one of the most frequent complaints the DAV hears from veterans evolves around the issue of a lack of basic courtesy and dignity exhibited by some VA employees when veterans seek to obtain medical care they are eligible for. Clearly, this needs to change.

Question 2: VA has said it must change and consistently provide veterans and their dependents with first class service. Which VA services are not consistently first class today? What are veterans' priorities for improving VA services?

Answer: In reply to the first question, it is our belief that as a whole, the VA health care system delivers a high level of quality care to veterans. As discussed above, the areas of general courtesy and treating veterans with dignity need to be addressed and improved. This issue should be addressed at the initial point of a veteran's contact with Medical Administrative Service. Most of the time when a veteran seeks medical care, the first person encountered is within this service. It is here that first impressions are so critical to everything else that occurs. As concerns the veterans' priorities for improving services, issues such as privacy, timeliness, easy access, bedside telephones, clinical space deficiencies, variety in the types of food available, and overall amenities rank high on veterans' lists. Veterans often do not know what services they are eligible for, which supports the critical need for eligibility reform. Additionally, an often heard complaint is the difficulty veterans have in adequate communications with their treating physicians.

Question 3: VA is reportedly overhauling its patient representative program. What improvements should VA make in the patient representative program?

Answer: Again, we believe the area of determining and then proactively addressing what veterans' needs are in a health care system should be first and foremost. We believe the patient representative should be empowered, at the local level, with the authority needed to achieve functional compliance with their stated mission. Consistent training, on a regularly scheduled basis, seems very important in order for the patient representatives to successfully complete their stated mission.

Question 4: Should VA care only be for veterans and their dependents? If VA purchases pediatric care for the enrollees of

its plan from a community practice group, should that community pediatric group be able to buy specialized care for VA for its patients who aren't enrolled in a VA plan?

Answer: First, it makes little sense to the DAV that a veteran would choose to receive care via the VA if their family members were denied the same opportunity. It is illogical to believe that veterans would go to one system -- VA -- for their care, while their spouse and dependents would be precluded from using the same system, and therefore, forced to choose a separate health care provider. Therefore, it is our belief that VA must offer veterans' dependents the opportunity to enroll in any VA health care plan. In your theoretical example, we believe, generally speaking, that a community practice group should be able to buy and purchase at fair market prices, specialized care and services from VA for patients who may not be enrolled in a VA plan. We would note these services need not and should not be only clinical in nature. We believe such a practice would create much needed additional funding streams to VA. Of course, our support for such a concept of contracting with the private sector, as well as the care of dependents, is wholly contingent on the premise that no otherwise eligible veteran would be denied services or have their medical care benefits diminished.

Question 5: **Please comment on the importance of physician choice for veterans and VA plan enrollees.**

Answer: Clearly, the choice of a health care system and provider to veterans, as well as the rest of the citizenry is very important in the context of National Health Care Reform. In our view, it becomes critical when confined to a VA health care plan. While now taking small steps, the VA needs to take giant strides in the direction of establishing not only a managed care system, but one that offers as its base, primary care. This, in our view, rounds out the need for a continuum of care to one that becomes one of quality and meets veterans' expectations.

HONORABLE LANE EVANS
ANSWERS TO QUESTIONS SUBMITTED FOR THE RECORD
DEPARTMENT OF VETERANS AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HEARING

VETERANS' PERCEPTIONS OF VA HEALTH CARE

APRIL 20, 1994

Question 1A: How many focus groups on VA health has VA conducted and how many veterans have participated in these focus groups?

Answer: Eight inpatient focus groups, approximately 90 patients and 40 family members. Four outpatient focus groups, approximately 40 patients and 15 family members.

Question 1B: When and where were these focus groups conducted?

Answer: Inpatient focus groups were conducted in April 1993 at four VA Medical Centers; Danville, Illinois; Reno, Nevada; Brockton/West Roxbury, Massachusetts; and Jackson, Mississippi; one medical center from each of the VA's four geographic regions.

Outpatient focus groups were conducted at the same times and locations as the inpatient focus groups. In addition, in March of 1994, one additional focus group was conducted with veterans who had attended outpatient clinics at the Brockton/West Roxbury VAMC at a local Boston area facility.

Question 1C: How did VA select the veterans who were invited to participate?

Answer: Inpatient focus groups: Veterans discharged within three months from an acute care hospitalization at four medical centers were called and asked to take part in a focus group about their inpatient care. Veterans who had experienced hospitalizations at different VA facilities any time in the past were particularly sought.

Outpatient focus groups: Veterans utilizing specialty and generalist care at each of the participating facilities. Again when possible, patients who had experienced care at more than one VAMC sometime in their past were selected.

Question 1D: What did VA tell veterans about these focus groups and their participation in them?

Answer: Veterans were told that the information they would provide would not be linked to who they are, and that taking part in the discussion group would not in any way affect their eligibility for VA benefits. In addition, those veterans who agreed to participate were told that the information they were providing would be used by VA to develop questionnaires that ask about aspects of care that the veterans tell us are important to them. Veterans were also told that the questionnaires would ultimately be used by every VAMC to assess how well the VAMC meets the veterans needs or wants.

Question 1E: Where were the focus groups conducted?

Answer: Focus groups were conducted at four VA Medical Centers: Danville, Reno, Brockton/West Roxbury and Jackson. In addition, the March 1994 focus group was conducted at a Boston area location that provided video taping capabilities.

Question 1F: In what respects were focus groups participants not representative of the veterans' population?

Answer: Long-term care and homeless patients were not included. Focus groups for the long-term care population are planned for FY 1995. We are also planning additional separate focus groups for the homeless patients, psychiatric patients and their family members.

By definition, focus group participants are a convenience sample. Patients who had the benefit of transportation to the facility and who were free at the time of the focus group meetings volunteered. For the March 1994 outpatient focus groups, transportation was donated by the Disabled American Veterans (DAV) from the medical center to the Boston area facility.

Question 1G: Did VA compensate focus group participants and if so, how?

Answer: Focus group participants were not monetarily compensated for their time. However, light refreshments were provided.

The Subcommittee understands the following VA inpatient care concerns were identified by VA focus group participants:

1. Respect for patient preferences;
2. Emotional support;
3. Continuity of care and transition to the community;
4. Patient education;
5. Family participation;
6. Communication with the patient; and
7. Physical comfort including pain management.

The Subcommittee also understands the following VA outpatient care concerns were identified by VA focus group participants:

1. Provider continuity and availability:
2. Timeliness of access;
3. Coordination and integration of care; and
4. Employee courtesy.

Question 1H: What other concerns (in addition to the 7 dimensions) did VA focus group participants express about VA inpatient care?

Answer: Patients did not volunteer concerns about facilities (food, housekeeping). The majority of concerns were about unquantifiable items, such as respect, communication, and emotional support (the 7 dimensions listed).

Question 1I: What other concerns did VA focus group participants express about VA outpatient care?

Answer: In addition to the four concerns listed, five concerns mentioned by inpatient focus group participants were also mentioned by outpatient participants. These include:

1. Respect for patient preferences
2. Emotional support
3. Patient education
4. Family participation
5. Patient communication

Specific additional concerns varied with each medical center. However, in general administrative issues (including check-in and check-out procedures, making an appointment, refilling medications and eligibility for total care at one facility) were mentioned more frequently than patient/provider interaction issues.

In general, in both inpatient and outpatient focus groups there was consensus that VAMCs obstruct by manner and behavior the patient's ability to get care. Veterans frequently feel that they are being treated as if they are trying to "get something for nothing" or take advantage of the system.

Question 1J: At which VHA facilities has VA taken action in response to the concerns identified and reported above?

Answer: Patient representatives at all VA facilities have shared their patients' concerns with local VA management. Interventions are varied and include increasing patient representative staffing and availability.

Question 1K: Please describe the actions taken in response to these concerns and the results of these actions.

Answer: These focus groups provided the foundation of information about VA patient population. In response to the concerns raised, VA developed an on-going patient feedback service. This service collects information, initially using focus groups. The information gained is used to develop statistically valid and reliable questionnaires. Throughout this process VA collaborates with the private sector to promote bench marking between the VA and private sector facilities, and within the VAMCs, nationally. In addition, the service will act as a knowledge-based resource center to provide individualized strategies and instruments for quality improvement to all VA facilities.

To date, information collected from the inpatient focus groups has been used to develop a questionnaire that was piloted at 20 VAMCs nationally, stratified by the four geographic regions. The results from this pilot are now being analyzed. Pending these analyses, the survey will be revised and administered to patients from all VAMCs nationally at the beginning of FY95.

Questionnaires for outpatient, long-term care, and special populations are under development. The patient feedback service will survey patients on an on-going basis to determine how each facility is meeting the needs of its patients. It is expected that the service will take over the function of administering surveys, which is currently performed by the patient representatives. This action will give more time to the patient representatives to play a more active role in conducting on-going patient focus groups at their facilities and utilizing the information gained.

Question 2: VA has recognized the need to change and consistently provide veterans and their dependents with first class service.

Which VA services are not consistently first class today?

What is VA's performance goal for each of these services?

How long will it take VA to provide these services in a first class fashion?

What are VA's top ten service improvement priorities?

What are VA's other priorities for improving services to veterans?

Answer: VA recognizes the need to improve in the area of customer service. Although many veterans are satisfied with their care, public perception has been marred by some negative publicity. Long waits for compensation and pension examinations, clinic appointment dates and in the waiting lounge are other areas VA recognizes as a need for improvement.

VA plans to move to a primary care model for health care delivery in a managed care environment. Each patient will have a primary care provider who will coordinate the continuum of services. This will be a more appropriate use of resources for improved quality and access to care. Another key to improving access is the establishment of health care networks. Networks will necessitate the flexibility to contract with health care providers in the communities where patients reside.

Question 3: Former Secretary Derwinski had two goals for VA: (1) provide the most compassionate care and highest quality service to veterans and their families and (2) be the most responsive and best managed service delivery organization in the federal government.

What has prevented achievement of these goals?

Answer: VA does provide high quality care to veterans and is, we believe, the most responsive and best managed of the federal health care provider systems. For example, VA scores an average of ten points higher on the Joint Commission Accreditation of Hospital Organization (JCAHO) reviews than its counterparts in the public sector. The JCAHO review board is established to set and enforce standards of health care delivery and management and is the most objective measure of VA's quality of care.

As with any system, improvements can be made, and are anticipated as outlined in the answer to question 2 above.

Question 4: What service improvements does VA expect to come from the VA National Partnership Council, a newly established joint labor-management partnership to improve VA services?

Answer: It is anticipated that union pre-decisional involvement in formulating VA programs and policies through the VA National Partnership Council will shorten the time needed for VA to implement its programs and policies. The statutory bargaining process adds from one month to two years to the time line for implementing new programs or policies affecting the working conditions of union represented employees. With pre-decisional involvement, unions may invoke their right to statutory bargaining less frequently. That would reduce the average time needed to implement programs and policies critical to improving the delivery of services to veterans and accomplishing National Performance Review objectives.

We also expect benefits from the ideas that unions and employees have about ways to improve the delivery of services to veterans. Consideration of that input in the pre-decisional development of VA's programs and policies will result in improved options and better support for decisions reached.

Question 5: Compare VA's customer service standards with the customer service standards of other health care providers.

Answer: Most private sector health care providers have methods to measure patient satisfaction, but have not set specific measurable standards. In 1991, in conjunction with the Picker-Commonwealth fund, VHA began to develop customer feedback data utilizing surveys from recently discharged inpatients, outpatients, and long-term care patients. These surveys have been and will continue to be tested for reliability and validity (inpatient surveys are completed, outpatient surveys are currently being piloted and long-term care surveys are in the beginning stages of development). Each question within the survey is measurable and can be tracked and trended. Several of the questions grouped together form qualitative standards and reflect what veterans have told us is important to them, i.e., communications, involvement in their care, etc. Using this methodology, VA is working with many facilities nationwide, including Harvard Medical School, in identifying and measuring what customers actually need, want, and expect and how we are meeting those customer requirements.

Question 6: How and when will VA correct scheduling and assignment problems, why haven't they been corrected already and what improvements has VA made since this Subcommittee's last hearing on the long waits and access problems veterans face for outpatient care?

Answer: As stated in our response to the Subcommittee dated October 27, 1993, we anticipate that all VA medical facilities will have some aspect of the telephone liaison care program operational by the end of fiscal year 1994. Automated recording capabilities for capturing telephone liaison visits were developed and available to field facilities February 1, 1994. Instructions and guidance were sent to field facilities via VHA Directive 10-94-022, dated March 18, 1994 (copy attached). Currently, it is difficult to determine the full impact telephone liaison care has had or will have on clinic availability and appointment scheduling. More definitive information will be available by April 1995.

VA is also developing a "primary care" approach for furnishing preventive health care, management of acute and chronic medical and mental health conditions, patient education and access to other components of health care such as long-term care and psycho-social support. These services were being provided in specialty clinic areas. It is anticipated that this reassignment will improve availability and scheduling in the clinics.

VHA has developed and released a computer software patch that will enable facilities to monitor the length of time of a clinic appointment. The software will enable each facility to obtain computer data for their overall facility average time, the clinic specific time, a service specific time or the patient specific time. This provides the mechanism for monitoring clinic times and making adjustments and/or improvements.

Question 7A: If VA health care quality is high, why aren't more current, former and non-users inclined to select a VA health care plan?

Answer: The Health Care Reform Customer Satisfaction Survey focused on veterans perceptions of VA health care. Veterans were asked about their views of VA health care and what influence this would have on their enrolling in a future VA health plan. Although the survey attempted to define the components of a VA health plan and describe how a plan would differ from the current hospital-based system, findings indicated that veterans based their responses on how they perceived VA health care today. Insofar as the current VA health care delivery system has had difficulty meeting the access demands

for all veterans, survey results should be viewed in the proper perspective and not as a definitive statement on how veterans will react under health care reform.

Question 7B: Why did one-quarter of current users indicate they would not select a VA sponsored health plan if current users give VA health care an above average satisfaction rating?

Answer: According to the survey, a significant number of current users indicated that the reason they would not select a VA sponsored health plan is because it would fail to provide adequate access to VA facilities or sufficient choice of physicians. Current users, like former and non-users surveyed, based their decision about enrolling in a VA sponsored health care plan on the current state of VA health care and not on what would be available to them under health care reform. Clearly, improving access - perhaps through use of contractors in local communities - and ensuring physician choice would make a VA health plan much more attractive to current users, particularly those who indicated that these were their reasons for selecting a non-VA health plan.

Question 7C: What changes would make VA the preferred option for these veterans?

Answer: In addition to improving access to care and ensuring physician choice, VA must implement other changes in its current health care delivery system if it is to be an attractive provider to current users as well as other veterans. Under health care reform, VA will offer veterans an annual report card that makes an objective comparison between VA health care and non-VA health care so that veterans can make an informed choice of health plan enrollment. VA will also construct a health insurance premium and benefits package that will be viewed by veterans as cost-effective and competitive when weighed against the offerings of other health plans.

Question 7D: When asked to choose between VA or another provider, with no change in cost, only 66% of current users picked VA, while 26% of current users picked a non-VA provider and 8% of current VA users were undecided. Is a separate and independent veterans health care system viable if only 66% of VA's current patients pick a VA plan?

Answer: It is not possible to know what percentage of current users are required in order to maintain VA as an independent system. The use of this measure would be misleading as it would ignore potential new enrollees including dependents.

Question 7E: What percent of current users does VA expect to enroll in a VA health care plan?

Answer: There are approximately 2.3 million current users of VA health care services. At this point in time, it is impossible to predict with any degree of accuracy how many current users, when given a choice of other health insurance, will actually enroll in a VA health plan. As the health care reform environment unfolds, the answer will become more evident.

Question 7F: What is the minimum number of enrollees required for an independent VA plan to be viable?

Answer: The fiscal viability of VA's health plan will be determined by the ability of local VA health plans across the country to successfully enroll veterans. With respect to the number of enrollees required for health plan viability, a literature search revealed some useful data on health plan

enrollment. According to an article in the January 14, 1993 edition of the New England Journal of Medicine entitled, "The Marketplace in Health Care Reform," the minimal population necessary to support a classic Health Maintenance Organization (HMO) offering referral hospital services and using its own staff physicians is approximately 450,000 enrollees. Furthermore, a health plan with 300,000 enrollees would be able to offer virtually all ambulatory and hospital services with its own panel of providers and own a 600 bed hospital.

On the basis of this research, VA may be able to project the number of enrollees required for national health plan viability by first predicting the number of veterans who would enroll in each local VA health plan. However, until health care reform legislation is passed, it is impossible for VA to know how many VA health plans will be established across the country or how many veterans can be expected to enroll in each plan.

Question 8: Please comment on the patient care scenario described in VVA's testimony?

Answer: For VA to remain a viable, independent system, it is necessary for VA to function in concert with major trends in health care. As the country adopts a policy of universal health care coverage, veterans who currently use VA will have additional options and may elect to seek care through other providers. For VA to succeed in the future, it must meet the standards for performance in an increasingly competitive health care market and meet or exceed our customers' expectations that the quality, cost and accessibility of VA care and service make VA a better choice than other plans.

VA must become a more customer service-driven organization to make us competitive with other health plans. An aggressive customer service strategic plan must become a priority. Everything from financial management to patient care delivery must reflect a consistent theme of customer satisfaction. To achieve our customer service vision, VA must, among other things, develop a national customer service plan, establish employee performance standards and incentives, continuously obtain customer feedback both individually and through organized groups that represent VA's customers, and provide patient amenities and visitor services that reflect VA's attention to customer satisfaction and facilitate easy access and active involvement of families and other caregivers.

Question 9: Will more successful VA facilities subsidize less successful VA facilities?

Answer: No. More successful VA facilities will not subsidize less successful ones. The President's plan includes a 3 year, $3.3 billion investment fund to help VA facilities compete under health care reform.

Question 10: Will VA's plan offer as much physician choice as any other plan?

Answer: Between VA staff physicians as well as physician coverage for specialty care and local accessibility arranged for by contract, we anticipate that VA will have a truly competitive range of practitioners from which the veteran or dependent enrollee may choose. The only limitation of choice of a doctor within a VA health plan is whether a particular doctor chooses to affiliate with the VA plan or not. A beneficiary desiring to receive care from a physician not associated with a VA plan would, naturally, still have the opportunity to obtain that care outside the plan. However, we fully expect to have a wide range of physician choices to satisfy plan enrollees consistent with provisions of the Health Security Act and criteria established for all health plans.

Question 11A: How much did VA pay a market research firm to survey current and former VA patients and veterans who had never used VA?

Answer: VA paid the firm of Hollander Cohen & McBride of Towson, Maryland approximately $45,000 to conduct the Health Care Reform Customer Satisfaction Survey. The purpose of the survey was to analyze the market potential for a VA health plan. The survey focused on veterans perceptions of VA health care and the likelihood of their enrolling in a future VA health plan. Approximately 1500 veterans randomly selected from across the country participated in ten minute telephone interviews conducted during a three week period in February, 1994.

Question 11B: What did VA learn from this survey that was not previously known?

Answer: Survey results indicated that a significant number of current users (66 percent) as well as a surprising number of former users (47 percent), and non-users (27 percent) expressed an interest in enrolling in a future VA health plan. The survey also brought to light the reasons current users would reject a VA health plan which turned out to be problems that are correctable by the establishment of VA Health Plans, e.g., inadequate access and physician choice. Factors of quality and lack of amenities were perceived less significant in influencing veterans choice than previously believed. Another significant finding from the survey was that the provision in the President's Health Security Act which permits VA to market its health care services to veterans and their dependents was viewed by respondents as a very positive development that would influence their decision to enroll in a VA health plan. It should be noted that the numbers in this survey represent a snapshot in time rather than a prediction. The more veterans become aware of the choices available to them under health care reform, the greater the likelihood that these numbers will change.

Question 11C: How has VA used the results of this survey?

Answer: VA will use the results from this and other surveys to develop preliminary estimates for veteran enrollment in a VA health plan. These estimates will need to be validated and strengthened by additional market research such as focus groups and comprehensive national customer surveys, after health care reform is enacted. Based upon the generally favorable perceptions that veterans had toward enrolling in a VA health plan (66 percent of current users, 47 percent of former users, and 27 percent of non-users), survey findings establish that a significant market potential exists for a VA health plan and increases exponentially when veterans' dependents are added. In addition to survey findings, VA has shared the survey instrument and sampling methodology with field facilities so that they might conduct their own survey research at the local level. To date, several VA medical centers have expressed an interest in taking advantage of this opportunity to assess their veteran population. VA will use the results to focus on these factors veterans cited as the main reasons for not selecting VA Plans as areas for improvement.

Question 12A: How much will it cost VA "to conduct highly visible marketing and advertising campaigns to meet with the aggressive advertising of other providers?" When will this marketing and advertising campaign begin?

Answer: Until full baseline market research studies have been performed on VA's health care market, exact funding requirements for advertising to that market can only be estimated. It is generally accepted within the advertising community that about 2 percent of revenues per year are necessary to successfully conduct a nationwide marketing effort.

Question 12B: What constraints does VA face conducting marketing and advertising campaigns?

Answer: While we have our obligation currently to inform veterans of VA benefits, we have no clear authority to do advertising per se. The Health Security Act would give VA clear authority to promote, market and advertise, however, it would not permit use of appropriated funds for these purposes.

Question 12C: How will VA respond to current negative perceptions of VA health care? How much will this cost?

Answer: A recent market survey conducted by VA indicated that among current and former users of VA services who indicated they would select VA as a health care plan, 67 percent and 72 percent respectively cited good service/quality of care and satisfaction with VA care as the number one reason for selecting VA. Poor quality was not cited as the major reason for not picking VA. Building a positive image is included in the estimated 2 percent of revenue projected for marketing and advertising use.

Question 13: Dr. Headley has stated that the "make or buy" question is important for VA. Will VA buy a service from a provider in which a VA employee has a financial interest?

Answer: VA employees are prohibited from participating personally or substantially on behalf of the Government in contracts to buy services from providers in which the employees have a financial interest if the contract will have a direct and predictable effect on that interest. However, VA facilities may contract with such providers if employees with financial interest are prohibited from participating in the contract negotiations. Many VA health care professionals have dual appointments with affiliated universities and medical schools. As a result, they typically have a financial interest in that institution and are, consequently, barred from participating in the contract for medical services with the affiliate.

Question 14: Under what conditions is VA providing care to non-veterans today?

If VA purchased pediatric care from a community pediatric group for VA plan enrollees, would VA be willing to provide a specialized care, such as orthopedics for example, to patients of that community pediatric care group who were not enrolled in a VA plan?

Answer: VA currently provides limited care to some non-veterans under the following circumstances:

Humanitarian care (in emergency situations to anyone presenting at a VA facility) CHAMPVA beneficiaries (to the extent services and facilities are available)

VA employees (as beneficiaries of Workers' Compensation program)

Beneficiaries of other Federal departments or agencies (under the Economy Act)

Patients of public and private sharing partners (under approved resource sharing agreements)

Department of Defense (DoD) beneficiaries, including CHAMPUS eligibles (under 38 U.S.C. 8111, and P.L. 102-585).

Care provided under sharing agreements and the Economy Act does not normally include inpatient treatment. DoD beneficiaries, however, are excepted, and inpatient care may be provided to non-veteran CHAMPUS eligibles provided that it is given pursuant to an agreement that improves services to veterans and such care does not result in delay or denial of access to care for any veteran.

VA would not normally provide inpatient care to community care groups for those who are not enrolled in a VA plan. However, it would be imprudent to flatly rule out such an arrangement in the future if the net effect would be of clear benefit to veteran enrollees and their dependents.

Question 15: VA plans to make health care as readily accessible as possible to plan enrollees living in remote or rural areas. What does, "as readily accessible as possible" mean?

How readily accessible will care be to other VA plan enrollees?

Answer: The Health Security Act requires that the National Health Board establish standards for all health plans. These standards will most likely include criteria for accessibility for service in terms of distance as well as the timeliness of service. The VA Health Plan would, at a minimum, adhere to the National Health Care Standards in order to expand services to primary care for plan enrollees. The VA would provide these services to enrollees living in remote and rural areas through a variety of contractual arrangements, such as sharing agreements with affiliates or the Department of Defense, the establishment of preferred provider networks, and individual contracts. These arrangements will include the establishment of community-based clinics to improve accessibility. Enrollees would have the choice of providers within the VA network. Enrollees could opt to obtain care outside the VA network but would accrue a higher cost share if they did so.

Question 16: If VA establishes networks of providers and plan enrollees can obtain care from any network member, will some VA plan enrollees rarely obtain care from VA directly?

Answer: Possibly. Use of VA facilities or contract providers in a VA plan network would be a choice available to all enrollees. VA will have a variety of health delivery systems within its plans. To meet access standards established by the National Health Board or other standard-setting groups VA must expand it's network of health care providers to include those close to the veterans' home. We anticipate that some veterans may not receive any care directly from VA facilities. Enrollees would probably obtain primary care and preventive services from their local providers to maintain optimal personal health. Routine medical services for those who are healthy through most of their lifetimes may be totally provided by their local health practitioner. More serious illnesses will be evaluated on a utilization review model to determine the best avenue for providing care.

Question 17: Other plans will also establish networks of providers for their enrollees.

Why will providers choose to be part of a VA plan network instead of another plan network if they choose not to be a part of both networks?

How will VA make participation in its plan the more attractive alternative?

Answer: VA begins with a number of competitive advantages. They include: a pre-established target population, lower cost to the consumer, transportable coverage, a national communications network, and value added services.

Through a proven, well-established and highly respected track record of providing physician opportunities in research, education and training, providers will be attracted to and exclusively retained by VA health plans. For more than 40 years, VA has worked in partnership with medical and dental schools to train physicians, dentists and other health care professionals to meet the patient care needs of veterans and to expand medical knowledge through research. The partnership between VA and its academic affiliates is highly successful.

VA offers research opportunities that the non-university private sector cannot. VA's research and development program has been and will continue to be a major factor influencing the recruitment and retention of high quality physician staff, the benefits of an academic/research milieu, and the availability of the latest and most advanced diagnostic and treatment techniques. VA will conduct research across its complete mix of primary, secondary, and tertiary care facilities within and across the health care plans. Contract providers who spend a majority of their time caring for VA health plan enrollees will be eligible for VA research funds. VA research will expand its efforts to help providers develop the skills to identify important questions.

Question 18: Describe the changes and restructuring VA has identified as necessary to be successful.

How much will it cost to accomplish these changes and restructuring and how long will it take?

What competitive advantages does VA have today?

What competitive disadvantages does VA have today?

Answer: In the competitive arena of health care reform, the ultimate success of VA is dependent on its ability to provide first-rate customer service. VA plans to transform from a multi-hospital, provider-oriented system into a patient-centered organization. This will require a balance of local autonomy and authority with respect to hiring practices, infrastructure mix ("build or buy" decisions) and contracting flexibility, with centralized guidance and oversight to prevent a collection of localized and potentially inconsistent systems without common visions or missions. The managed care model to be adopted by VA will utilize a variety of delivery models to achieve improved clinical care and enhanced resource management and utilization control. Primary care clinics with a focus on preventive care will be community-based and alleviate accessibility problems which currently exist in VA.

Part of VA's restructuring plan was to implement Veteran Service Areas (VSAs). VSAs would allow smaller regional units than the four that currently exist. This plan will be re-visited upon the arrival of a new Under Secretary for Health.

Because we do not know the final configuration of the comprehensive benefit package, nor the degree to which VA will be allowed to implement competitiveness changes, we do not know what the cost of restructuring will be. Likewise, the time frame for implementation is unknown, because of lack of finalization of details in the President's reform plan.

Competitive advantages enjoyed by VA include:

a. A dependable revenue stream to support ongoing patient care operations.

b. A cadre of loyal, long-term customers and supporters, particularly including Veteran Service Organizations.

c. A stable workforce.

d. Nationally-recognized expertise in specialized areas of health care, specifically including post-traumatic stress disorder and substance abuse treatment; spinal cord injury and blind rehabilitation care; prosthetics and sensory aids services; geriatric care and AIDS research and care.

Our competitive disadvantages include:

a. Historic episodic care and focus on inpatient hospital based system as opposed to a managed care/primary care outpatient focus.
b. Public image.

c. Lack of experience in free-market competition and business orientation.

Question 19A: "Patient representative reports provide medical center management with direct information regarding patient satisfaction and the patient's view of the quality of the care and services being provided," according to VA.

VA is reported to be overhauling its patient representative program. Has VA asked veterans and their service organizations to recommend improvements in VA's patient representative program? What improvements in VA's patient representative program have veterans and their service organizations recommended?

Answer: VA appointed a National Patient Representation Program Manager in the fall of 1993. This individual is in the process of contacting national service organizations, i.e., American Legion, Disabled American Veterans, Veterans of Foreign Wars, to request an opportunity to speak at their conventions, conferences, and workshops about the Patient Representation Program, and to request recommendations for improvements the Patient Representative can implement in VA medical centers.

Question 19B: Does each VA medical facility have at least one full-time equivalent patient representative? How many VA facilities have more than one FTEE patient representative?

Answer: In October 1990, the Secretary for Veterans Affairs mandated each VA medical center to have one FTEE designated as Patient Representative. There are approximately 25 VA medical centers with more than one FTEE Patient Representative.

Question 19C: What are the results of the most recent assessment of the effectiveness of VA's patient representative program and which facilities have the most effective and best patient representative programs in VA?

Answer: The National Patient Representation Program Manager has initialized systemwide site visits to evaluate the program and its effectiveness in meeting the veteran's needs. As the result of recent site visits and feedback from the field six facilities were identified as having an effective Patient Representation Program (Danville, Lexington, Mountain Home, San Diego, Salem and Topeka). However, there are several other facilities not yet evaluated and may be considered as having better or equally as effective programs. The goal is to identify approximately twelve patient representation programs which function at the highest level. These local programs will be used as models for new and struggling patient representation programs. They will be monitored on a continuous basis.

Question 20: How and where has TQM improved VA delivery of services to veterans and their dependents?

Answer: Total Quality Management (TQM) is a philosophy that espouses organizational values that have been proven to increase efficiency and effectiveness. Included among these are continuous improvement, data driven decision-making, customer focus, and empowerment of employees. Veterans Health Administration (VHA) has been implementing TQM using a three-phased approach. The first phase began in FY 1992 and involved 13 VA medical facilities. It was devoted to learning how to apply TQM principles and techniques in a health care environment, and the 13 Phase I sites were appropriately called "pilot" sites. Late in FY 1992, 25 medical facilities were added in Phase II. In late FY 1993, over 100 medical facilities were added to VHA's TQM roster in a final Phase III. To date, almost all VA medical facilities are involved in implementing TQM principles and techniques. Anecdotal evidence of improved services to veterans abound. A sampling of quality activity from competition finalists for the prestigious Robert W. Carey Quality Award, the Department's highest award for quality, illustrates the kind of results VA medical facilities are achieving by applying TQM techniques and principles.

Albany, New York, VA Medical Center (1993 Carey Award overall winner) developed a clinical pathway for total hip replacement that reduced in-hospital length of stay and improved patient and staff satisfaction.

Canandaigua, New York, VA Medical Center (1993 Carey Award Honorable Mention) received "Commendation" status from Joint Commission on Accreditation of Healthcare Organizations.

Kansas City, Kansas, VA Medical Center (1992 Carey Health Care Category winner) developed a peer review process recognized as a "model" and used to improve numerous aspects of patient care such as significant decreases in lengths of stay and mortality rates.

Indianapolis, Indiana, VA Medical Center has developed a program whereby employees volunteer time to assist in feeding patients.

Oklahoma City, Oklahoma, VA Medical Center reorganized its Cardiology Clinic and reduced waiting time dramatically for new cardiology appointments.

Dayton, Ohio, VA Medical Center achieved a substantial improvement in the timeliness of administration of thrombolytic therapy.

San Diego, California, VA Medical Center achieved a significant decrease in cases of aspiration pneumonia.

Tuscaloosa, Alabama, VA Medical Center achieved significant improvements in numerous measures of patient satisfaction including staff courtesy, medications and special needs.

White City, Oregon, Domiciliary reduced patient injury incidents by over half in the past two years.

ATTACHMENT TO QUESTION #6

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 10-94-022

March 18, 1994

TELEPHONE LIAISON CARE PROGRAM (TLCP)

1. PURPOSE: The purpose of this Veterans Health Administration (VHA) Directive is to provide guidance for establishment of local Telephone Liaison Care Programs.

2. BACKGROUND: Department of Veterans Affairs (VA) is committed to developing innovative programs to improve our customer focus. Telephone Liaison Care programs have the potential for improving access to care providers, reducing unnecessary clinic visits and decreasing waiting times.

3. POLICY: Every VA medical facility will develop and institute a Telephone Liaison Care Program, the goal of which will be to allow patients and families to contact the facility by telephone to discuss any concerns relevant to access to care, (eligibility and scheduling), medical concerns, (treatment and follow-up), and questions about medications.

4. ACTION

a. Telephone Liaison Care is a part of any facility's Ambulatory Care Program. It should be available to all patients and integrated into existing health care delivery systems including firms, primary care programs and urgent care clinics.

b. Telephone Liaison Care should be provided by qualified individuals who have been provided clear guidance and training. A facility may provide telephone access using staff members from a variety of services (e.g., Medical Administration, Nursing, Pharmacy) to address issues relevant to their individual services and responsibilities. In all cases there must be coordination among services to ensure that interdisciplinary problems are fully addressed.

c. Individuals providing Telephone Liaison Care must have ready access to patient medical records, including current pharmacy profiles. In most cases, this will require access to the hospital computer system.

d. Clinical advice may be provided only by registered nurses, physicians, physician assistants, or other individuals who, in the opinion of the Chief of Staff, or designee, are qualified by virtue of training and experience.

e. Stop codes have been established for each respective cost distribution account and are defined in Attachment A. Telephone visits are defined as a telephone call between clinical/professional staff and a patient:

(1) To coordinate medical clinical/advice to an established patient on a new problem,

(2) To initiate therapy that can be coordinated by telephone,

(3) To discuss test results in detail,

(4) To provide medication refills or adjust medications, or

(5) To initiate a new plan of care.

f. Telephone calls concerning. eligibility or other administrative issues do not constitute a telephone visit as no medical intervention is involved.

g. Telephone visits will be counted as facility workload for budgeting purposes.

h. Those specialties, i.e., Social Work, Nursing, Dietetics, Psychology, etc., which are reported in Cost Distribution Report (CDR) account 2611.00 that want to report workload activities may establish specific clinics with their treating specialty stop codes and the telephone/ancillary stop code number 147.

i. The Medical Care Cost Recovery Program Office has determined that health care services provided via telephone contacts are nonbillable as outpatient visits to insurance carriers. These visits will not result in a billable event, however, should the telephone contact result in the provision of a prescription or a refill, the $2.00 prescription copayment will be required if applicable. When the telephone contact results in the provision of a new prescription or a refill, a claim will be submitted to the insurance carrier for a prescription refill.

j. Activities accomplished through TLCP must be documented in the patient's medical record (or electronic medical record). The provisions of the Privacy Act, Title 5, United States Code, Section 552a, and 38 U.S.C. Section 7332, which concern the privacy and confidentiality of patient information, apply to any conversations relative to a patient's condition and/or treatment with individuals other than the patient.

k. Every facility must have a mechanism for making patients aware of its Telephone Liaison Care Program, including the phone number, a description of the types of problems which are appropriate for calls, hours of operation and instructions for obtaining services during non-administrative hours.

l. Telephone Liaison Care should be monitored and evaluated on an ongoing basis as part of the facility's Quality Management activities.

5. REFERENCES

a. General Accounting Office Report (GAO-HRD 94-4), "VA Health Care. Restructuring VA's Ambulatory Care System Would Improve Services to Veterans," dated October 15, 1993.

b. Office of Inspector General Report (3R6-A99-154), "Audit of Outpatient Waiting Times in Department of Veterans Affairs Medical Centers," dated September 30, 1993.

c. M-1, Part I, Chapter 16, Paragraph 16.17, "Scheduling."

d. M-1, Part I, Chapter 9.

6. FOLLOW-UP RESPONSIBILITY: Deputy ADCMD for Ambulatory Care (112).

7. RESCISSIONS: This VHA Directive will expire on March 18, 1997.

John T. Farrar, M.D.
Acting Under Secretary for Health

Attachment

DISTRIBUTION: CO: E-mailed 3/21/94
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ATTACHMENT A

NEW CLINIC STOP CODES
**added in middle of Fiscal Year 1994

STOP CODE	CDR ACCOUNT	DEFINITION
103	2111.00	Telephone Triage: Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and the clinical/professional staff assigned to the admission/emergency services area. Includes administrative and clinical services.
324	2110.00	Telephone/Medicine: Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the medicine service. Includes the administrative and clinical services.
424	2210.00	Telephone/Surgery: Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and the clinical/professional staff assigned to the surgical service. Includes the administrative and clinical services.
526	2310.00	Telephone/Special Psychiatry: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the special psychiatry service. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus, or sickle cell anemia, are strictly confidential and may not be released/discussed unless there is a written consent from the individual.

527	2311.00	Telephone/General Psychiatry: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the general psychiatry service. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus, or sickle cell anemia, are strictly confidential and may not be released/discussed unless there is a written consent from the individual.
542	2313.00	Telephone/PTSD: Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the PTSD Clinical Team. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus, or sickle cell anemia, are strictly confidential and may not be released/discussed unless there is a written consent from the individual.
543	2316.00	Telephone/Alcohol Dependence: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the alcohol dependence treatment team. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus, or sickle cell anemia, are strictly confidential and may not be released/discussed unless there is a written consent from the individual.

544	2316.00	Telephone/Drug Dependence: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the drug dependence treatment team. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus, or sickle cell anemia, are strictly confidential and may not be released/discussed unless there is a written consent from the individual.
545	2316.00	Telephone/Substance Abuse: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to the substance abuse treatment team. Includes the administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with human immunodeficiency virus, or sickle cell anemia, are strictly confidential and may not be released/discussed unless there is a written consent from the individual.
147	2610.00	Telephone/Ancillary Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to: Nursing, public health nursing, nutrition/dietetics, social work service, or clinical pharmacy. Includes administrative and clinical services.

216	2611.00	Telephone/Rehab. and Support: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to rehabilitation and support services. Includes administrative and clinical services.
148	2612	Telephone/Diagnostic: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff associated with: pulmonary function, x-ray, EEG, EKG, laboratory, nuclear medicine, ultrasound, evoked potential, topographical brain mapping. Includes administrative and professional services.
425	2614.00	Telephone: Prosthetics/Orthotics: Records patient consultation or medical care management/ advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to prosthetics/orthotics. Includes administrative and professional services.
181	2710.00	Telephone/Dental: Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to Dental service. Includes administrative and professional services.
611	2410.00	Telephone/Dialysis: Records patient consultation or medical care management/advice/referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical/professional staff assigned to Dialysis treatment team. Includes administrative and professional services.

525	2311.00	WOMEN'S STRESS DISORDER TREATMENT TEAMS: Records contacts with veterans seen by Women's Stress Disorder Treatment teams at officially Central Office (CO) designated VA Medical Centers.

RESPONSES TO QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

VETERANS' PERCEPTIONS OF VA HEALTH CARE
APRIL 20, 1994

QUESTIONS FOR MR. DAVID P. BAINE
DIRECTOR
FEDERAL HEALTH CARE DELIVERY ISSUES
HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION
U.S. GENERAL ACCOUNTING OFFICE

1. **What actions did GAO take to avoid bias among veterans who participated in the focus groups?**

We did the following to recruit participants for the 14 focus groups: For 12 groups, we started with information on veterans from the Department of Veterans Affairs' (VA) compensation and pension files. We identified low income veterans, those with service-connected disabilities rated at less than 50 percent and 50 percent or more, Medicare eligible veterans, and female veterans. For the other two groups, we started with data from the Office of Personnel Management and the Department of Interior to identify federal employees who claimed veterans' preference when hired.

Using names and addresses, we looked up veterans' telephone numbers. We called people on the list systematically until we found 12 to 15 veterans who agreed to attend in anticipation that 8 to 10 veterans would actually participate. We called approximately 7 veterans for every veteran who agreed to participate.

In general, telephone calls to veterans were made in the late afternoon and early evening on weekdays or during the daytime on weekends. During the telephone conversations, respondents were told that GAO was seeking participants for small group discussions to talk about veterans' health care issues. Respondents were asked to confirm their veteran status, when they last used the VA health system and whether they might like to participate. Those veterans who agreed to participate were paid a nominal amount to defray travel expenses.

In summary, we attempted to avoid bias by making telephone calls to veterans in off hours, by attempting to contact a large number of veterans, by holding the discussions at convenient times in neutral locations, and by offering travel reimbursement for participants.

2. **VA is already competing to provide health care to some veterans. How is VA doing?**

We have not assessed VA's performance in competing for veterans in states that have implemented health reforms and cannot speak directly to this point. In Hawaii, which was the first state to come close to universal coverage, demand for VA care is well below national averages.

What improvements has VA made since GAO testified before this Subcommittee on the long waits and access problems veterans face for outpatient care?

VA has formulated corrective action plans to address the service delays and access problems identified in our testimony. However, we have not returned to the individual facilities to see how well

these plans have been implemented. We intend to revisit this issue in the near future to see what improvements have been made.

3. **What should VA do to retain the veterans who currently use VA?**

Absent health reform, VA needs to address shortcomings in customer service and improve the convenience of getting care in their facilities. Changes needed to compete in health reform will depend, to some extent, on the health reform provisions that are enacted. At a minimum, VA will have to provide the benefits that other health plans offer at a comparable, or perhaps lower, cost. To retain its veteran population, VA may have to expand services and offer care for veterans' dependents.

Why do some prefer VA health care?

There are myriad reasons why veterans prefer VA health care. Many veterans use VA solely for the treatment of their service-connected disability, because they feel as if they are owed such care by the government, or perhaps because the disability is considered a preexisting condition by their other health plans. Some veterans use VA because they feel more comfortable getting treatment at VA than elsewhere and are confident that VA offers quality health care. Finally, certain veterans use VA health care, because they do not have access to other health care, or their health insurance does not cover the types of services they receive from VA.

What changes in VA health care did these veterans want?

Most broadly stated, veterans feel that VA needs to streamline its eligibility requirements, move away from offering episodic health care and treat the needs of the patient as a whole. Although veterans' perceptions of VA's care differed significantly by location, in general, veterans see a need for VA to improve its customer service and humanize its treatment of patients. Veterans also see a need for VA to reduce scheduling delays and minimize waiting times.

4. **What should VA do to attract veterans who don't now use VA?**

As a first step, VA should make the changes listed above and market those improvements to the veteran community it wants to attract. VA should also consider offering supplemental services or specialized care to attract this targeted population. Finally, VA facilities should be given the autonomy to respond to local needs and circumstances as necessary. Such changes, however, would also create increased risks in terms of costs, quality access to care and potential for fraud and abuse.

Why do some veterans prefer non-VA health care?

Veterans cited past negative experiences with VA, strong ongoing relationships with non-VA health care providers, distance from VA facilities, inconvenience associated with using VA, and desire to use family oriented health care providers as reasons to prefer non-VA health care. We are currently preparing a report for Senator Murkowski that will provide additional information on the reasons veterans choose not to use VA.

What changes would make VA more attractive to these veterans?

VA may never be able to attract certain of these veterans, e.g., those with strongly negative experiences or those with strong ties to non-VA providers. VA may want to consider developing provider networks by contracting with community providers or building satellite clinics to increase veterans' access to

outpatient services. VA may be able to appeal to veterans by improving its customer service, enhancing its reputation and marketing the value of its services to this population. Another option would be to offer additional services or services with lower out-of-pocket costs.

5. How could VA use the information GAO gathered on veterans perceptions to improve service to veterans?

The veterans in the focus groups provided a wealth of information on both the positive and negative aspects of VA health care. Veterans' perceptions of VA's advantages can be used to strengthen its market position in health reform. Many of the concerns with VA care that veterans discussed are longstanding problems known by the VA. Some of these issues, such as restricted eligibility, cannot be readily addressed by VA without legislative changes. Others such as waiting times and service delays appear to be resolvable within VA's current structure.

The American Legion
For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006-2847 ★
(202) 861-2700 ★

May 20, 1994

Honorable Lane Evans, Chairman
Subcommittee on Oversight
and Investigations
Committee on Veterans Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Evans:

The American Legion is pleased to respond to additional questions concerning the April 20, 1994, hearing on Veterans' Perceptions of VA Health Care.

1. **What customer service standards should VA establish for veterans health care?**

Reply

VA must deliver quality, courteous, compassionate and timely health care. Veterans should not have to wait longer for a scheduled outpatient clinic appointment than would be reasonably expected in the local community. VA must set and meet standards on the length of time required to schedule various outpatient appointments. Under health care reform, if VA cannot meet established time standards, eligible beneficiaries should be provided contract care. Additionally, VA beneficiaries should not have to travel greater distances for care than is routine in their local community.

Other customer service standards should reflect appropriate physical accommodations and adequate patient privacy.

Ultimately, we believe VA must conduct customer surveys to fully understand and incorporate veterans views in the establishment of system wide customer service standards.

2. **VA has said it must change and consistently provide veterans and their dependents with first class service.**

A. Which VA services are not consistently first class today?

B. What are veterans' priorities for improving VA services?

Reply

We believe the following answer is applicable to both questions.

Veterans' priorities for improving VA health care are the same as for the non-veteran community. Access to care and the availability of a full range of clinical services is important. So, too, is the quality of care, timeliness of care, and a medically oriented continuum of care. Under the present VA system, it is our view that veterans are less interested in a wide range of patient amenities than they are in being able to trust and have confidence in their health care providers. Veterans need to have the assurance that their health care needs will be provided in a manner that is consistent with local health care standards.

3. VA is reportedly overhauling its patient representative program.

A. What improvements should VA make in the patient representative program?

Reply

Assure that Patient Representatives are true veterans' advocates and not a fence around the facility director.

System wide program standards must be set to establish the representative's patient load, qualifications for the position, and required tracking and trending reports. We favor the idea of instituting outside reviews of the Patient Representative Program, possibly within the reviews conducted by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

We believe there must be consistency in who the Patient Representative reports to within the facility, a visibly identified location for the position, and printed brochures about the program available to veterans throughout the facility.

The system wide coordinator for the program has to be more visible and available to veterans service organizations on a national level, and should be involved with VA's marketing plans for the implementation of health care reform.

4. Should VA care only be for veterans and their dependents?

A. If VA purchases pediatric care for the enrollees of its plan from a community practice, should that community pediatric group be able to buy specialized care from VA for its patients who aren't enrolled in a VA plan?

Reply

Only if VA is able to provide such care and the care required is for adult patients. Beyond providing humanitarian care, we do not favor VA becoming involved in providing direct care to dependent children.

5. Please comment on the importance of physician choice for veterans and VA plan enrollees.

Reply

The proposed VA primary care concept would not emphasize physicians' choice by patients. However, after initial physician consultation and treatment, a veteran or other VA plan enrollee would be followed by a primary care team. It needs to be made clear under what conditions private practice physicians will be permitted to contract with VA. In most instances, local VA physicians would be able to provide necessary medical treatment. In cases where VA facilities are geographically inaccessible to veterans and their dependent enrollees, the Legion would favor physician choice through contract care.

Sincerely,

John Vitikacs

John Vitikacs
Assistant Director
National Veterans Affairs and
Rehabilitation Commission

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

Responses To Questions
Submitted by
The Honorable Lane Evans, Chairman
Subcommittee on Oversight and Investigations
House Committee on Veterans' Affairs
Regarding April 20, 1994 Hearing
On Veterans Perceptions of VA Health Care

1. What customer service standards should VA establish for veterans health care?

The Paralyzed Veterans of America (PVA) believes that the national debate relative to health care reform has had a positive effect upon the Veterans Health Administration (VHA). The debate has caused VHA to look closely at its system of health care delivery and identify problem areas that require correction if VHA is to compete with the private sector under health care reform. It should be noted that regardless of passage of H.R. 3600, the "Health Security Act", or similar legislation that places VHA into the competitive environment of health care delivery, changes need to be made. If VHA is to be successful in attracting enrollees into any VA health plan it must identify its areas of weakness in customer service and take corrective action. VA should establish customer service standards of excellence that place VA on the cutting edge in the delivery of medical care.

These standards of excellence should exist for all components of the VA health care system and include such areas as:

a. Standards of excellence that provide proper screening techniques in the hiring of health care professionals and support staff which includes an ongoing evaluation process.

b. Standards of excellence that ensure the availability of state of the art technology and equipment for the diagnosis and treatment of disease or injury.

c. Standards of excellence that provide facilities that are structurally safe, clean, and capable of accommodating changing medical technology.

2. VA has said it must change and consistently provide veterans and their dependents with first class service.

Which VA services are not consistently first class today?

What are veterans' priorities for improving VA services?

PVA believes the following areas of customer service require improvement:

a. **Excessive waiting times.** Unless VA can significantly reduce waiting times that meet or exceed private sector standards patients will not select VA as their health care provider. The Dallas VAMC has made significant improvements in reducing patient waiting times for unscheduled appointments from about two hours to an average of 27 minutes.

b. **VA should optimize the utilization of shared and contracted services.** VA facility directors must optimize the utilization of shared and contracted services for care they are not able to provide in-house in a timely manner.

c. **Patient information.** Patients should be provided information that explains their medical condition and recommended treatment programs whenever possible.

d. **Extended hours of operation.** VA should investigate the feasibility for longer clinic hours on weekdays and some weekend hours to make clinics more accessible.

e. **Customer service training.** VA should consider providing in-house customer service training for employees that is focused on patient courtesy and the importance of developing personal listening skills.

f. **Employee recognition.** Any customer service program must include a employee recognition program. These programs contribute to employee morale and reinforce the goals of consumer service.

g. **Patient meals.** Private sector hospitals offer a variety of entree choices for each meal. VA should attempt to offer as many menu choices as possible.

h. **Patient room amenities.** Basic room amenities such as telephones, television and private restroom facilities are taken for granted in the private hospital sector. While individuals realize that these amenities do not improve the quality of health care they receive they are personal comforts that are expected. VA must make improvements in their physical plant and provide these basic amenities in their hospital rooms.

NOTE: PVA believes that the priority for improving VA services must always be focused upon the delivery of quality medical care. Amenities that increase personal comfort are also important to a patients well being and PVA believes that resources should be provided to accomplish both goals.

3. VA is reportedly overhauling its patient representative program.

   What improvements should VA make in the patient representative program?

PVA believes that one of the primary roles of Veteran Service Organizations (VSOs) is to serve as an advocate for the veteran within the Veterans Health Administration. **Therefore, PVA recommends** that as VA works to review its patient representative program that it create a VSO advisory committee to participate in the review process. This recommendation is not without precedent as VA recently included the VSOs in the development of their plan for operation under health care reform. **PVA believes** that VA staff and a VSO advisory committee would be able to discuss the roles and responsibilities of the patient representative and discover solutions that belay our concerns.

PVA is concerned about the organizational alignment of the position of VA patient representative. PVA is concerned that possible conflicts of interest could exist as the patient representative attempts to serve as advocate for the veteran and at the same time satisfy the demands of his supervisor, the director of the VAMC. Perhaps the position of patient representative should be filled by means of a contract agreement

with an individual or agency outside VA and should not be filled by an employee of the health care provider.

Currently the Department of Health and Human Services is conducting a study of the effectiveness of state long-term care Ombudsman programs. One of the major topics of the study is the question of conflict of interest in the administration and operation of the programs. (Attachment I.)

4. Should VA care only be for veterans and their dependents?

VA has a history of serving patients other than veterans through contracts and sharing agreements. PVA believes that these contracts and sharing agreements have been beneficial to all concerned. However, PVA feels strongly that VAs first and foremost obligation is to care for its veteran patients. Under no situation should VA treat non-veteran patients at the expense of those it was created to serve.

5. Please comment on the importance of physician choice for veterans and VA plan enrollees.

When veterans were asked what they value most about their private-sector health plans, the most common response seemed to be their choice of physician (PVA Focus Groups, Summer 1993).

Because of VAs academic affiliations' rotation schedules for medical residents, VA may not always have the option of providing physician choice. There are ways, however, in which VA can enhance a patient's control over his or her choice of provider.

First, VA medical centers could assign patients to one provider or "team" of providers. Some VA medical centers could consider allowing patients to choose their physician or team rather than randomly assigning patients. Second, according to VAs plan for operation under health care reform VA will move to become a primary health care delivery system. Under this system VA would be able to offer greater freedom of physician choice to plan enrollees.

provisions set out as notes under this section and sections 1975c, 3021 and 3045 of this title and repealed provision set out as a note under section 3056 of this title] may be cited as the 'Comprehensive Older Americans Act Amendments of 1978'."

Short Title of 1975 Amendment

Pub.L. 89-73, Title V, § 501, formerly Title IX, § 901, as added by Pub.L. 94-135, Title I, § 113(a), Nov. 28, 1975, 89 Stat. 720, and renumbered by Pub.L. 95-478, Title I, § 105(a), Oct. 18, 1978, 92 Stat. 1547, provided: "That this Act [which enacted chapter 76 and sections 3002(4) to (6), 3020a, 3024(d), 3028(a)(6) to (7), 3034(c), 3046f(d), and 3056 to 3056f of this title, amended sections 2996-5, 3002(1), 3012(a)(8), 3014(c), 3015(g), (h), 3022(1), 3023(a), (b), 3024(e)(2), (4), 3025, 3026(b), 3029(b), 3033, 3034(a), 3037, 3037a(b), 3041d(a), 3041f(b)(1), 3045b(c), (d), 3045d(a)(2), (5), (c), 3045e(a)(5), (8), 3045f, 3046g, 5011(a), (b), 5012(a)(1), and 5082(a), (b)(1) of this title and sections 1008a(b), 1208a(b), and 1341(d) of Title 20, repealed sections 3061 to 3067 of this title, enacted provisions set out as notes under section 5001 of this title and section 871 of Title 29, and amended provisions set out as a note under section 2809 of this title] may be cited as the 'Older Americans Amendments of 1975'."

Study of Effectiveness of State Long-Term Care Ombudsman Programs

Section 211 of Pub.L. 102-375, as amended Pub.L. 103-171, § 4(a)(2), Dec. 2, 1993, 107 Stat. 1991, provided that: "Not later than January 1, 1996, the Commissioner on Aging shall, in consultation with State agencies, State Long-Term Care Ombudsman, the National Ombudsman Resource Center established under section 202(a)(21) of the Older Americans Act of 1965 [section 3012(a)(21) of this title] (as added by section 202(b)(2) of this Act [section 202(b)(2) of Pub.L. 102-375, Sept. 30, 1992, 106 Stat. 1195, for distribution of which, see Short Title note set out under this section and Tables]), and professional ombudsmen associations, directly, or by grant or contract, conduct a study, and submit a report to the committees specified in section 207(b)(2) of such Act [section 3018(b)(2) of this title], analyzing separately with respect to each State—

"(1) the availability of services, and the unmet need for services, under the State Long-Term Care Ombudsman programs in effect under sections 307(a)(12) and 712 [sections 3027(a)(12) and 3058q of this title] of the Older Americans Act of 1965 (42 U.S.C. 3001 et seq. [this chapter]) to residents of long-term care facilities (as defined in section 102 of such Act [section 3002 of this title]);

"(2) the effectiveness of the programs in providing the services to the residents, including residents of board and care facilities (as defined in section 102 of such Act [section 3002 of this title]) and of similar adult care facilities;

"(3) the adequacy of Federal and other resources available to carry out the programs on a statewide basis in each State;

"(4) compliance and barriers to such compliance of the States in carrying out the programs;

"(5) any actual and potential conflicts of interest in the administration and operation of the programs; and

"(6) the need for and feasibility of providing ombudsman services to older individuals (as defined in section 102 of such Act [section 3002 of this title]) who are not in long-term care facilities and who use long-term care services and other health care services, by analyzing and assessing current State agency practices in programs in which the State Long-Term Care Ombudsmen provide services to older individuals in settings in addition to long-term care facilities, taking into account variations in—

"(A) settings where services are provided;

"(B) the types of clients served;

"(C) the types of complaints and problems handled;

"(D) State regulation of long-term care provided in settings other than long-term care facilities; and

"(E) possible conflicts of interest between the State Long-Term Care Ombudsman programs under such Act [this chapter] and area agencies on aging (as defined in section 102 of such Act [section 3002 of this title]) who provide to older individuals long-term care services both in such settings and in long-term care facilities."

Study on Board and Care Facility Quality for Older Individuals

Section 212 of Pub.L. 102-375 provided that:

"(a) Arrangement for study committee.—The Secretary of Health and Human Services shall enter into an arrangement, in accordance with subsection (d), to establish a study committee described in subsection (c) to conduct a study through the Institute of Medicine of the National Academy of Sciences on the quality of board and care facilities for older individuals (as defined in section 102 [section 3002 of this title] of the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.) [this chapter]) and the disabled.

"(b) Scope of study.—The study shall include—

"(1) an examination of existing quality, health, and safety requirements for board and care facilities and the enforcement of such requirements for their adequacy and effectiveness, with special attention to their effectiveness in promoting good personal care;

"(2) an examination of, and recommendations with respect to, the appropriate role of Federal, State, and local governments in assuring the health and safety of residents of board and care facilities; and

"(3) specific recommendations to the Congress and the Secretary, by not later than 20 months after the date of the enactment of this Act [Sept. 30, 1992], concerning the establishment of minimum national standards for the quality, health, and safety of residents of such facilities and the enforcement of such standards.

"(c) Composition of study committee.—The study committee shall be composed of members as appointed from among the following:

"(1) National Academy of Sciences.—The members of the National Academy of Sciences with experience in long-term care. The members so appointed shall include—

"(A) physicians;

"(B) experts on the administration of drugs to older individuals, and disabled individuals receiving long-term care services; and

"(C) experts on the enforcement of life-safety codes in long-term care facilities.

"(2) Residents.—Residents of board and care facilities (including privately owned board and care facilities), and representatives of such residents or of organizations that advocate on behalf of such residents. Members so appointed shall include—

"(A) residents of a nonprofit board and care facility; or

"(B) individuals who represent—

"(i) residents of nonprofit board and care facilities; or

"(ii) organizations that advocate on behalf of residents of nonprofit board and care facilities.

"(3) Operators.—Operators of board and care facilities (including privately owned board and care facilities), and individuals who represent such operators or organizations that represent the interests of such operators. Members so appointed shall include—

"(A) operators of a nonprofit board and care facility; or

"(B) individuals who represent—

"(i) operators of nonprofit board and care facilities; or

"(ii) organizations that represent the interests of operators of nonprofit board and care facilities.

"(4) Officers.—

"(A) State officers.—Elected and appointed State officers who have responsibility relating to the health and safety of residents of board and care facilities.

"(B) Representatives.—Representatives of such officers or of organizations representing such officers.

"(C) Other individuals.—Other individuals with relevant expertise.

"(d) Use of Institute of Medicine.—The Secretary shall request the National Academy of Sciences, through the Institute of Medicine, to establish, appoint, and provide administrative support for the study committee under an arrangement under which the actual expenses incurred by the Academy in carrying out such functions will be paid by the Secretary. If the National Academy of Sciences is willing to do so, the Secretary shall enter into such arrangement with the Academy.

"(e) Involvement of others.—

"(1) Government officials.—The study committee shall conduct its work in a manner that provides for the consultation with Members of Congress or their representatives, officials of the Department of Health and Human Services, and officials of State and local governments who are not members of the study committee.

"(2) Experts.—The study committee may consult with any individual or organization with expertise relating to the issues involved in the activities of the study committee.

"(f) Report.—Not later than 20 months after an arrangement is entered into under subsection (d), the study committee shall submit, to the Secretary, the Speaker of the House of Representatives, and the President pro tempore of the Senate, a report containing the results of the study referred to in subsection (a) and the recommendations made under subsection (b).

"(g) Board and care facility defined.—In this section, the term 'board and care facility' means a facility described in section 1616(e) of the Social Security Act (42 U.S.C. 1772a(e)) [section 1772a(e) of this title]).

"(h) Authorization.—There are authorized to be appropriated to carry out this section $1,500,000 for fiscal year 1992 and such sums as may be necessary for subsequent fiscal years."

Study on Home Care Quality for Older Individuals

Section 213 of Pub.L. 102-375 provided that:

"(a) Establishment study of committee.—The Secretary of Health and Human Services shall enter into an arrangement, in accordance with subsection (d), to establish a study committee described in subsection (c) to conduct a study through the Institute of Medicine of the National Academy of Sciences on the quality of home care services for older individuals and disabled individuals.

"(b) Scope of study.—The study shall include—

"(1) an examination of existing quality, health and safety requirements for home care services and the enforcement of such requirements for their adequacy, effectiveness, and appropriateness;

"(2) an examination of, and recommendations with respect to, the appropriate role of Federal, State, and local governments in ensuring the health and safety of patients and clients of home care services; and

"(3) specific recommendations to the Congress and the Secretary, not later than 30 months after the date of the enactment of this Act [Sept. 30, 1992], concerning the establishment of minimum national standards for the quality, health, and safety of patients and clients of such services and the enforcement of such standards.

"(c) Composition of study committee.—The study committee shall be composed of members appointed from among—

"(1) individuals with experience in long-term care, including nonmedical home care services;

"(2) patients and clients of home care services (including privately provided home care services and services funded under the Older Americans Act of 1965 [this chapter]) or individuals who represent such patients and clients or organizations that advocate on behalf of such patients and clients;

"(3) providers of home care services (including privately provided home care services and services funded under the Older Americans Act of 1965 [this chapter]) or individuals

who represent such providers or organizations that advocate on behalf of such providers;

"(4) elected and appointed State officers who have responsibility relating to the health and safety of patients and clients of home care services, or representatives of such officers or of organizations representing such officers; and

"(5) other individuals with relevant expertise.

"(d) Use of Institute of Medicine.—The Secretary shall request the National Academy of Sciences, through the Institute of Medicine, to establish, appoint, and provide administrative support for the committee under an arrangement under which the actual expenses incurred by the Academy in carrying out such functions will be paid by the Secretary. If the National Academy of Sciences is willing to do so, the Secretary shall enter into such arrangement with the Academy.

"(e) Involvement of others.—

"(1) Members and officials.—The committee shall conduct its work in a manner that provides for consultation with Members of Congress or their representatives, officials of the Department of Health and Human Services, and officials of State and local governments who are not members of the committee.

"(2) Individual or organization with expertise.—The committee may consult with any individual or organization with expertise relating to the issues involved in the activities of the committee.

"(f) Report.—Not later than 20 months after an arrangement is entered into under subsection (d), the committee shall submit, to the Secretary, the Speaker of the House of Representatives, and the President pro tempore of the Senate, a report containing the results of the study referred to in subsection (a).

"(g) Authorization.—There are authorized to be appropriated to carry out this section $1,500,000 for fiscal year 1992 and such sums as may be necessary for subsequent fiscal years."

Long-Term Health Care Workers

Sections 801 through 804 of Pub.L. 102-375 provided that:

"Sec. 801. Definitions.

"As used in this subtitle [this note]:

"(1) Nursing home nurse aide.—The term 'nursing home nurse aide' means an individual employed at a nursing or convalescent home who assists in the care of patients at such home under the direction of nursing and medical staff.

"(2) Home health care aide.—The term 'home health care aide' means an individual who—

"(A) is employed by a government, charitable, nonprofit, or proprietary agency; and

"(B) cares for elderly, convalescent, or handicapped individuals in the home of the individuals by performing routine home assistance (such as housecleaning, cooking, and laundry) and assisting in the health care of such individuals under the direction of a physician or nurse.

"Sec. 802. Information requirements.

"(a) National Center for Health Statistics.—The Director of the National Center for Health Statistics of the Centers for Disease Control shall collect, and prepare a report containing—

"(1) demographic information on home health care aides and nursing home nurse aides, including information on the—

"(A) age, race, marital status, education, number of children and other dependents, gender, and primary language, of the aides; and

"(B) location of facilities at which the aides are employed in—

"(i) rural communities; or

"(ii) urban or suburban communities; and

"(2) information on the role of the aides in providing institution-based and home-based long-term care.

"(b) Department of Labor.—The Secretary of Labor shall—

"(1) collect, and prepare a report containing, information on home health care aides, including—

"(A) information on conditions of employment, including—

"(i) the length of employment of the aides with the current employer of the aides;

"(ii) the number of aides who are—

"(I) employed by a for-profit employer;

"(II) employed by a nonprofit private employer;

"(III) employed by a charitable employer;

"(IV) employed by a government employer; or

"(V) independent contractors;

"(iii) the number of full-time, part-time, and temporary positions for the aides;

"(iv) the ratio of the aides to professional staff;

"(v) the types of tasks performed by the aides, the level of skill needed to perform the tasks, and whether the tasks are completed in a institution-based or home-based setting; and

"(vi) the average number and range of hours worked each week by the aides; and

"(B) information on availability of the employment benefits for home health care aides and a description of the benefits, including—

"(i) information on health insurance coverage;

"(ii) the type of pension plan coverage;

"(iii) the amount of vacation leave;

"(iv) wage rates; and

"(v) the extent of work-related training provided; and

"(2) collect, and prepare a report containing, information on nursing home nurse aides, including—

"(A) the information described in subparagraphs (A) and (B) of paragraph (1); and

"(B) information on—

"(i) the type of facility of the employer of the aides, such as a skilled nursing facility, as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i-3(a) [section 1395i-3(a) of this title]), or an intermediate care facility within the meaning of section 1121(a) of the Social Security Act (42 U.S.C. 1320a(a) [section 1320a(a) of this title]);

"(ii) the number of beds at the facility; and

"(iii) the ratio of the aides to residents of the facility.

"Sec. 803. Reports.

"(a) Reports to Commissioner on Aging.—

"(1) Transmittal.—

"(A) National Center for Health Statistics report.—Not later than March 1, 1994, the Director of the National Center for Health Statistics of the Centers for Disease Control shall transmit to the Commissioner on Aging the report required by section 802(a).

"(B) Department of Labor reports.—

"(i) Home health care aides.—Not later than March 1, 1993, the Secretary of Labor shall transmit to the Commissioner on Aging a plan for the collection of the information described in section 802(b)(1). Not later than March 1, 1995, the Secretary of Labor shall transmit to the Commissioner on Aging the report required by section 802(b)(1).

"(ii) Nursing home nurse aides.—Not later than March 1, 1994, the Secretary of Labor shall transmit to the Commissioner on Aging the report required by section 802(b)(2).

"(2) Preparation.—

"(A) National Center for Health Statistics report.—The report required by section 802(a) shall be prepared and organized in such a manner as the Director of the National Center for Health Statistics may determine to be appropriate.

"(B) Department of Labor reports.—The reports required by paragraphs (1) and (2) of section 802(b) shall be prepared and organized in such a manner as the Secretary of Labor may determine to be appropriate.

"(3) Presentation of information.—The reports required by section 802 shall not identify by name individuals supplying information for purposes of the reports. The reports shall present information collected in the aggregate.

"(b) Report to Congress.—The Commissioner on Aging shall review the reports required by section 802 and shall submit to the appropriate committees of Congress a report containing—

"(1) the reports required by section 802;

"(2) the comments of the Commissioner on the reports; and

"(3) additional information, regarding the roles of nursing home nurse aides and home health care aides in providing long-term care, obtained through the State Long-Term Care Ombudsman program established under sections 307(a)(12) and 712 of the Older Americans Act of 1965 [sections 3027(a)(12) and 3058g of this title].

"Sec. 804. Occupational code.

The Secretary of Labor shall include an occupational code covering nursing home nurse aides and an occupational code covering home health care aides in each wage survey of relevant industries conducted by the Department of Labor that begins after the date of enactment of this Act [Sept. 30, 1992]."

Limitation on Authority to Enter Into Contracts

Section 901 of Pub.L. 102-375 provided that: "Any authority to enter into contracts under this Act [Pub.L. 102-375, Sept. 30, 1992, 106 Stat. 1195, the Older American Act Amendments of 1992; for distribution of this Act to the Code, see Short Title note set out under this section and Tables], or an amendment made by this Act shall be effective only to the extent or in such amounts as are provided in advance in appropriations Acts."

Promulgation of Regulations

Section 902 of Pub.L. 102-375 provided that: "Except as otherwise specifically provided, the Secretary of Health and Human Services shall, not later than 120 days after the date of the enactment of this Act [Sept. 30, 1992], issue proposed regulations to carry out the amendments made by titles I through VII [Titles I through VII, sections 101 through 708, of Pub.L. 102-375 for classification of such provisions to the Code, see Tables]."

White House Conference On Aging

Sections 201 to 207 of Pub.L. 100-175, as amended Pub.L. 102-375, Title VIII, §§ 801-804, 806(a), Sept. 30, 1992, 106 Stat. 1300-1305; Pub.L. 103-171, § 6, Dec. 2, 1993, 107 Stat. 1992, provided that:

"Sec. 201. White House Conference authorized.

"(a) Findings.—The Congress finds that—

"(1) the number of individuals 55 years of age or older was approximately 52,225,000 in 1990, and will, by the year 2040, be approximately 108,646,000;

"(2) more than 1 of every 8 persons 55 years of age or older will be hospitalized during the next year;

"(3) the out-of-pocket costs to older individuals for health care increased from 12.3 percent in 1977 to 18.2 percent in 1988;

"(4) there is a great need to ensure access and the quality of affordable health care to all older individuals;

"(5) the need for a comprehensive and responsive long-term care delivery system is great;

"(6) the availability and cost of suitable housing, together with suitable services needed for independent or semi-independent living, still cause concern to older individuals;

"(7) the ability to lead an independent or semi-independent life is contingent, in many cases, upon the availability of a comprehensive and effective social service system for older individuals.

THE HONORABLE LANE EVANS, CHAIR
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HEARING ON APRIL 20, 1994
QUESTIONS SUBMITTED FOR THE RECORD
VIETNAM VETERANS OF AMERICA

1. What customer service standards should VA establish for veterans health care?

VA health plans should meet or exceed the customer service standards in each community in which it operates. This may vary from site to site. For instance wait times for outpatient doctor visits may be longer or shorter in some locales; customers in some areas may expect certain amenities that are not common everywhere; and choice of physicians or access to specialists would certainly vary in smaller or larger communities. VA must provide at least the standard that is common among its local competitors -- preferably it can provide better customer service. Eventually VA should set the community standard rather than struggle to meet it.

2. VA has said it must change and consistently provide veterans and their dependents with first class service. Which VA services are not consistently first class today? What are veterans' priorities for improving VA services?

Again, the current service quality varies from site to site, and veterans' expectations and priorities vary accordingly. In some VA service areas, for instance, veterans are completely satisfied with the customer service provided at VA facilities, but may be concerned about the lack of a substance abuse ward. In other locations, VA may provide a complete range of services, but veterans are frustrated by rude employees and the poor appearance and cleanliness of the facilities. Both customer service standards and service improvement priorities should be set by local directors -- not VA Central Office -- working with advisory groups which include representatives of state veterans' affairs departments, local spokespersons of federal legislators, health care professionals from inside and outside the VA, and most importantly the veteran consumers themselves. In this way, directors can be responsive to the local veterans' needs and expectations. Those directors who fail to do so should be given direction from VA Central Office and/or should be removed, but the standards and priorities must be set locally.

3. VA is reportedly overhauling its patient representative program. What improvements should VA make in the patient representative program?

Some of the most innovative ideas VVA has noted for making the patient representative program successful were discussed during VA's Health Care Reform Project work groups. One VAMC director discussed that he has 6 patient representatives and makes them directly responsible to him. Open communication to the director seems to alleviate some problems and makes the VAMC more responsive to the patients needs.

In addition, this director said the service representatives at his facility are not stationary, waiting for patients to come to them with problems. The patient representatives patrol the entire VAMC looking for potential problems. For instance if the patient representative notices that a patient has been waiting for a long period, the service representative checks out the situation to determine if there is a problem.

VVA suggests that this type of approach is ideal and should be duplicated throughout the system. It is imperative that local directors be prepared for the new competitive role VA will play within the nation's health care delivery system. Local directors should pattern their administrative staff after successful private sector hospitals and providers. It is important that local directors provide incentives to employees to be customer service oriented, and that the very real need to be responsive to patient needs is directed and reinforced from the top. Certainly Central Office should provide direction, but it is more important that a customer service-orientation be driven from the local leadership. Local leaders who fail to do this should be given direction and/or replaced.

*4. **Should VA care only be for veterans and their dependents? If VA purchases pediatric care for the enrollees of its plan from a community practice group, should that community pediatric group be able to buy specialized care from VA for its patients who aren't enrolled in a VA plan?***

As we have seen in the past, it is politically difficult to promote the concept that VA should be opened to treat non-veterans. For some veterans advocacy organizations it is difficult even to accept the admittance of veterans' dependents. From a perspective of efficient business practices, however, it would be irresponsible to allow underused resources to lie idle. Because Americans purchase health care in family units, denying the dependents care through the VA would mean the loss of many potential veteran users. VVA supports the inclusion of veterans' dependents in the VA health plan under national health care reform.

VVA is not opposed to having VA sell its surplus services to non-veterans, provided that care for veterans is accommodated first. We are aware that in special instances and on a limited basis, VA already has such sharing arrangements which provide care for non-veterans. It is our understanding that national health care reform will allow all veterans who want to use VA services to have access, thus no veteran will be denied VA care. Selling VA's surplus services under these conditions is therefore palatable. For purposes of ensuring that no veterans are denied care, it is important that local managers closely monitor utilization of services and programs. Ideally local managers will collaborate with the aforementioned advisory groups to complete these monitoring tasks.

To make this concept acceptable to those organizations who do have concerns, however, we would suggest that this be depicted as a sharing arrangement in which veterans are able to access services more easily than would be the case without the exchange of services between the VA and the community provider.

*5. **Please comment on the importance of physician choice for veterans and VA plan enrollees.***

Physician choice is an important issue within the national health care reform debate for both veterans and non-veterans alike. It seems that current VA users complain more about being forced to see a different physician on every visit, than they do about the lack of choices in which physicians they see. Consistency in providers is perhaps more important to current VA patients than a choice between different physicians.

In order to be competitive in the new health care environment, VA also needs to implement a system of primary care which utilizes nurse practitioners and physicians assistants. This would ensure that veterans and their families would receive consistent, cost-effective treatment. Primary care and case management services have proven to be the best approach to dealing with multiple health problems. This also ensures maximum utilization of available resources. VVA believes that the competency and consistency of primary health care providers is more important to the future stability of the VA health system than is individual physician choice.

JEWISH WAR VETERANS OF THE
UNITED STATES OF AMERICA, INC.

Herb Rosenbleeth
Colonel, USA (Ret)
National Executive Director

June 10, 1994

Chartered by an Act of Congress

The Honorable Lane Evans
Chairman
U.S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Evans:

In response to your letter of May 5, 1994, following are your questions and my responses:

1. Q. What customer service standards should VA establish for veterans health care?

   A. The VA must establish customer service standards at least equal to, and preferably better than, the rest of the health care industry.

   VA employees must get the message that customer service is one of their highest priorities.

2. Q. VA has said it must change and consistently provide veterans and their dependents with first class service.

   Which VA services are not consistently first class today?

   What are veterans' priorities for improving VA services?

   A. Appointment responses are too slow throughout the system. The number one complaint we get, with the possible exception of the attitude of VA employees, is that appointments are not available in a reasonable time.

   Long term care capability is inadequate to meet the needs of veterans. JWV wants to see additional long term care capability in almost all locations.

3. Q. VA is reportedly overhauling its patient representative program.

What improvements should VA make in the patient representative program?

A. It is recommended that the VA make two changes in the patient representative program. First, the patient representative should stay with the problem until it is resolved, and not pass the problem on to someone else. Second, some or perhaps many patient representatives, are also assistants in the hospital public relations department. This is a conflict of interest. Each patient representative should be focused on helping the patient, not simultaneously trying to protect the hospital's image.

4. Q. Should VA care only be for veterans and their dependents?

If VA purchases pediatric care for the enrollees of its plan from a community practice group, should that community pediatric group be able to buy specialized care from VA for its patients who aren't enrolled in a VA plan?

A. Our organization's position is that VA health care facilities should be for veterans only until veterans' needs are fully met and there is still excess availability of staff and funds.

5. Q. Please comment on the importance of physician choice for veterans and VA plan enrollees.

A. It is very, very important that veterans have physician choice. Many disabled veterans have used the same physician for decades. Patients want to see a physician with whom they have a rapport and in whom they have confidence.

Very truly yours,

Herb Rosenbleeth
National Executive Director

HR:IB

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

May 24, 1994

Chairman Lane Evans
Subcommittee on Oversight
and Investigations
House Committee on Veterans Affairs
U.S. House of Representatives
Washington, D.C. 21515

Dear Chairman Evans:

Please find below the VFW's responses to your questions regarding veterans health care. It is my pleasure to provide you with this information.

1. What customer service standards should VA establish for veterans health care?

RESPONSE: Veteran patients should always be treated as a wanted guest. This would include showing: concern for the patient; kindness toward the patient, and a willingness to discuss with them their condition.

2. VA has said it must change and consistently provide veterans and their dependents with first class service. Which VA services are not consistently first class today?

RESPONSE: The attitude of some employees, timeliness in getting appointments and seeing the physician, thoroughness of treatment and examination, condition of the facilities to include the space problems and the lack of proper staffing of care givers.

2a. What are veterans' priorities for improving VA services?

RESPONSE Veterans currently utilizing VA are very understanding of the problems facing them when they go to the VA. It will be important that VA face the problem with the quality of their treatment and examination of veterans seeking care for their medical conditions especially during off-hours and in the emergency rooms. Next they should make the timeliness problem their next priority with the attitude problem a close third.

3. VA is reportedly overhauling its Patient Representative pro-

gram. What improvements should VA make in the Patient Representative program?

RESPONSE This is one of the best programs the VA has in those hospitals where the program is supported properly by top management. However too many Directors view the Patient Representative program as a collateral duty or they use the Patient Representative as a screen to keep unhappy patients out of their office. In too many cases the Patient Representative holds down other jobs which takes too much time away form their duties as Patient Representative. The Patient Representative program is understaffed at most facilities. To really improve the program the Patient Representative must be given the full backing of the Director and be placed directly under the Director's authority. Sufficient staffing must be given so that an individual can be assigned to the outpatient area during clinic times to handle any problem that comes up. The Patient Representative should not be stuck in an office away from the action.

4. Should VA care only be for veterans and their dependents?

RESPONSE The VFW is opposed to opening up VA medical facilities to non-veterans until such time as all eligible veterans, who wish, are being provided that care. If there is excess capacity we will be willing to discuss opening up the system to others.

4a. If VA purchases pediatric care for the enrollees of its plan from a community practice group, should that community pediatric group be able to buy specialized care from VA for its patients who aren't enrolled in a VA plan?

RESPONSE Keeping our position listed above in mind, the VFW does not oppose the sharing of scarce medical resources as long as it does not deny or delay any eligible veterans care.

5. Please comment on the importance of physician choice for veterans and VA plan enrollees.

RESPONSE As with most people veterans have a desire to control their lives. This would also pertain to choosing their physician. Most physicians in the VA are excellent, however, there are some veterans that for one reason or the other may not want to be treated by them. It would be important that they be given the opportunity to make a choice. Certain physicians would either have to mend their attitude, if that is the problem, or leave VA if they lose all their patients. I believe that when a veteran has the ability to choose a health plan the ability to choose the physician within that plan will be important.

Sincerly,

Dennis Cullinan, Deputy Director
National Legislative Serivce

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